SECTION 4 - BILLING SUPERVISOR MENU

Claims Tracking Menu for Billing
Enter/Edit Billing Information
Automated Means Test Billing Menu
Patient Billing Reports Menu
Management Reports (Billing) Menu
Medication Copayment Income Exemption Menu
MCCR System Definition Menu
Third Party Billing Menu
* Unbilled Amounts Menu

*Documentation for the Unbilled Amounts Menu, which was released to the field as patch IB*2*19, has been included in this section of the manual as a matter of convenience. The Unbilled Amounts Menu [IBT UNBILLED MENU] need not be assigned to the Billing Supervisor Menu. It may be assigned to any menu in Integrated Billing, or to a users's secondary menu, as deemed appropriate by IRMS.

Option Overview

MANAGEMENT REPORTS (BILLING) MENU

STATISTICAL REPORT (IB) - Lists the total number of Integrated Billing actions by action type along with the total charge by type for a date range.

MOST COMMONLY USED OUTPATIENT CPT CODES - Lists the most common ambulatory procedures and ambulatory surgeries performed within a date range for selected clinic(s).

CLERK PRODUCTIVITY - Allows you to print a report which lists all bills sorted alphabetically by the clerk who first entered the bill for a selected date range.

RANK INSURANCE CARRIERS BY AMOUNT BILLED - Generates a listing of insurance carriers ranked by the total amount billed.

BILLING RATES LIST - Prints a list of billing rates by effective date for a selected date range.

REVENUE CODE TOTALS BY RATE TYPE - Prints the total amount billed by revenue code for a selected rate type and date range.

BILL STATUS REPORT - Used to print a listing of bills and their status for a specified date range.

RATE TYPE BILLING TOTALS REPORT - Used to obtain a listing of all billing totals for each rate type for a specified date range.

INSURANCE PAYMENT TREND REPORT - Allows you to analyze payment trends among insurance companies, and track receivables which are due your facility.

UNBILLED BASC FOR INSURED PATIENT APPOINTMENTS - Lists all BASC (billable ambulatory surgical code) procedures for scheduled appointments of insured patients that could not be matched with BASC procedures entered on a bill for the patient for a selected date range.

MEDICATION COPAYMENT INCOME EXEMPTION MENU

PRINT CHARGES CANCELED DUE TO INCOME EXEMPTION - Prints a report which lists patients and medication copayment charges that are cancelled due to the income exemption (charges to patients determined to be exempt from the medication copayment requirement).

EDIT COPAY EXEMPTION LETTER - Allows you to edit the HEADER, MAIN BODY, and STARTING ADDRESS LINE fields in the IB FORM LETTER file (#354.6).

INQUIRE TO MEDICATION COPAY INCOME EXEMPTIONS - Prints a brief or full inquiry of exemptions for a patient. The brief inquiry is used to view past and/or present exemptions, and the full inquiry is used to view the entire audit history of all changes to a patient's exemption status.

MANUALLY CHANGE COPAY EXEMPTION (HARDSHIPS) - Grants and/or removes hardship waivers for patients who request the Copay Income Test.

LETTERS TO EXEMPT PATIENTS - Prints the letters to be sent to patients who have been determined to be exempt from the medication copay.

LIST INCOME THRESHOLDS - Prints an output which lists the income thresholds used in the medication copayment income exemption process sorted by type of threshold and effective date.

PRINT PATIENT EXEMPTIONS OR SUMMARY - Prints a list of copayment exemption statistics. Both exempt and non-exempt patients are included. Deceased patients are omitted.

REPRINT SINGLE INCOME TEST REMINDER LETTER - Used to generate an Income Test reminder letter for a patient whose effective copay exemption is based upon income.

ADD INCOME THRESHOLDS - Used to enter/edit the income thresholds used in the medication copayment income exemption.

PRINT/VERIFY PATIENT EXEMPTION STATUS - Searches the BILLING EXEMPTION file and compares the currently stored active exemption for each patient against what the system calculates to be the correct exemption status for the patient based on current data from the MAS files.

MCCR SYSTEM DEFINITION MENU

ENTER/EDIT AUTOMATED BILLING PARAMETERS - Used to enter or edit the parameters that control automated billing.

AMBULATORY SURGERY MAINTENANCE MENU

PRINT CHECK-OFF SHEET FOR APPOINTMENTS - Allows you to print Ambulatory Surgery Check-Off Sheets by patient name or clinic for a specified appointment date.

PURGE UPDATE FILE - Used to delete all CPT entries in the temporary file, UPDATE BILLABLE AMBULATORY SURGICAL CODE (#350.41) that have been successfully transferred to the permanent file, BILLABLE AMBULATORY SURGICAL CODE (#350.4).

LOCALITY MODIFIER ENTER/EDIT - Allows you to enter or edit division information for a specific effective date which directly affects CPT billing rates.

LIST TRANSFER ERRORS - Produces a listing of all entries in the temporary UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) that have not yet transferred to the permanent BILLABLE AMBULATORY SURGICAL CODE file (#350.4).

DELETE/LIST INACTIVE CODES ON CHECK-OFF SHEETS - Lists and deletes CPT codes that are AMA (American Medical Association) inactive or nationally, locally, and billing inactive from check-off sheets.

BUILD CPT CHECK-OFF SHEET - Allows you to build a new CPT check-off sheet or edit an existing one.

AMBULATORY SURGERY RATE EDIT - Allows you to enter or edit entries in the CPT RATE GROUP BILLING file.

CHECK OFF SHEET PRINT - Allows you to print Ambulatory Surgery Check-Off Sheets that have been set up through the Build CPT Check-off Sheet option.

RUN AMB. SURG. UPDATE - Used to transfer CPT (Current Procedural Terminology) codes from the temporary UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) to the permanent BILLABLE AMBULATORY SURGICAL CODE file (#350.4).

CHARGE MASTER MENU

ENTER/EDIT CHARGE MASTER - Used for the maintenance of Third Party rates and charges. It contains the List Manager screens which display all rate elements/fields.

PRINT CHARGE MASTER - Provides reports for all elements of the Charge Master and maintenance of Third Party rates.

FAST ENTER OF NEW BILLING RATES - This option is designed to allow quick entry of new rates into the Charge Master for Interagency and Tortiously Liable Billing Rates.

DELETE CHARGES FROM THE CHARGE MASTER - Used to delete charges from a Charge Set that are no longer needed.

INACTIVATE/LIST INACTIVE CODES IN CHARGE MASTER - This option searches the charges in the Charge Master for inactive CPT codes. It then inactivates all charges associated with those inactive CPT codes.

ENTER/EDIT BILLING RATES - Used to edit revenue code rates for each bedsection, per diem rates, the Medicare deductible (this is the only place the Medicare deductible is entered), the HCFA ambulatory surgery rates, and pharmacy copayment amounts that are used in the automatic calculation of costs when preparing a third party bill.

FAST ENTER OF NEW BILLING RATES - Designed to facilitate the rapid entry of billing rates for a fiscal year that will be used in the automatic calculation of costs when preparing a third party bill.

FLAG STOP CODES/DISPOSITIONS/CLINICS - Used to flag/unflag those stop codes and dispositions which should not be billed.

INSURANCE COMPANY ENTRY/EDIT - Used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies.

LIST FLAGGED STOP CODES/DISPOSITIONS/CLINICS - Produces a listing of all stop codes, dispositions, and clinics which have been flagged as not being billable for Means Test billing.

BILLING RATES LIST - Prints a list of billing rates by effective date for a selected date range.

MCCR SITE PARAMETER ENTER/EDIT - Allows you to define and edit the MCCR site specific billing parameters.

UPDATE RATE TYPE FILE - Used to add new entries to the RATE TYPE file or to edit existing entries.

MCCR SITE PARAMETER DISPLAY/EDIT - Consolidates parameters from the Enter/Edit IB Site Parameter, MCCR Site Parameter Enter/Edit, Claims Tracking Parameter Edit, and Enter/Edit Automated Billing Parameters options into one option.

THIRD PARTY JOINT INQUIRY - Provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care.

THIRD PARTY BILLING MENU - Option overviews are located under Section 1, Billing Clerk's Menu.

UNBILLED AMOUNTS MENU

RE-GENERATE AVERAGE BILL AMOUNTS - Used to rebuild and store the monthly and yearly counts and dollar amounts of inpatient and outpatient bills for a single month.

RE-GENERATE UNBILLED AMOUNTS REPORT - Used to regenerate the Unbilled Amounts Report for a single month.

SEND TEST UNBILLED AMOUNTS BULLETIN - Allows you to send a test mail message to the mail group receiving the unbilled amounts messages.

VIEW UNBILLED AMOUNTS - Used to view previously computed unbilled amounts without having to re-compile the data.

Management Reports (Billing) Menu
Statistical Report (IB)

INTRODUCTION

This report lists the total number of Integrated Billing actions by action type along with the total charge by type for a date range. Integrated Billing actions include inpatient copayments by treating specialty, inpatient and NHCU per diems; and NHCU, outpatient, and pharmacy copayments.

Net statistics compute the current status for each new entry in the selected date range to calculate the net totals. Net totals are derived from the last update for a parent (even when the update is not within the date range) using the following formula: new entries (+) updates within the date range (-) cancellations.

The gross statistics count only the entries in the date range. It is possible that the net and gross statistics may not match. For example, if a charge was cancelled after the selected date range of the report but before the report actually ran, the net figures would reflect this but the gross figures would not.

Due to the brevity of this option, a process chart is not provided.

Management Reports (Billing) Menu
Statistical Report (IB)

EXAMPLE
The following is an example of what may appear on your screen while using the Statistical Report (IB) option. User responses are shown in boldface type. An example of the output begins on the following page.

```
Integrated Billing Statistical Report


Start with DATE: T  (JUN 10, 1992)
Go to DATE: T  (JUN 10, 1992)
Output Device: HOME// A137-10/6/UP     HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

Management Reports (Billing) Menu
Statistical Report (IB)

EXAMPLE, cont.

```
INTEGRATED BILLING STATISTICAL REPORT
ALBANY (500)

From: JUN 10, 1992
To: JUN 10, 1992

Date Printed: JUN 10, 1992
Page: 1
-------------------------

NET TOTALS BY ACTION TYPE

                    FEE SERVICE (OPT) NEW
                             NUMBER ENTRIES: 1
                             DOLLAR AMOUNT: $30

                     INPT COPAY (ALC) NEW
                             NUMBER ENTRIES: 0
                             DOLLAR AMOUNT: $0

                     INPT COPAY (PSY) NEW
                             NUMBER ENTRIES: 1
                             DOLLAR AMOUNT: $162

                        INPT PER DIEM NEW
                             NUMBER ENTRIES: 1
                             DOLLAR AMOUNT: $10

                           OPT COPAY NEW
                             NUMBER ENTRIES: 13
                             DOLLAR AMOUNT: $390

                         SC RX CO PAY NEW
                             NUMBER ENTRIES: 5
                             DOLLAR AMOUNT: $24

                      NSC RX COPAY UPDATE
                             NUMBER ENTRIES: 1
                             DOLLAR AMOUNT: $2

                           GROSS TOTALS BY ACTION TYPE

                    FEE SERVICE (OPT) NEW
                             NUMBER ENTRIES: 1
                             DOLLAR AMOUNT: $30

                     INPT COPAY (ALC) NEW
                             NUMBER ENTRIES: 1
                             DOLLAR AMOUNT: $238
```

Management Reports (Billing) Menu
Statistical Report (IB)

EXAMPLE, cont.

```
INTEGRATED BILLING STATISTICAL REPORT
ALBANY (500)

From: JUN 10, 1992
To: JUN 10, 1992

Date Printed: JUN 10, 1992
Page: 2
-------------------------

                    INPT COPAY (PSY) NEW
                            NUMBER ENTRIES: 1
                            DOLLAR AMOUNT: $162

                       INPT PER DIEM NEW
                            NUMBER ENTRIES: 1
                            DOLLAR AMOUNT: $10

                          OPT COPAY NEW
                            NUMBER ENTRIES: 16
                            DOLLAR AMOUNT: $480

                        NSC RX COPAY NEW
                            NUMBER ENTRIE S: 1
                            DOLLAR AMOUNT: $2

                         SC RX COPAY NEW
                            NUMBER ENTRIES: 5
                            DOLLAR AMOUNT: $28

                 INPT COPAY (ALC) CANCEL
                             NUMBER ENTRIES: 1
                            DOLLAR AMOUNT: $238

                         OPT COPAY CANCEL
                            NUMBER ENTRIES: 3
                            DOLLAR AMOUNT: $90

                     NSC RX COPAY CANCEL
                            NUMBER ENTRIES: 2
                            DOLLAR AMOUNT: $44

                      SC RX COPAY UPDATE
                            NUMBER ENTRIES: 1
                            DOLLAR AMOUNT: $4
```

Management Reports (Billing) Menu
Most Commonly used Outpatient CPT Codes

INTRODUCTION

This option will list the most common ambulatory procedures and ambulatory surgeries performed within a date range for selected clinic(s). This list may be used to help select which codes to include when building CPT check-off sheets through the Build CPT Check-off Sheet option under the Ambulatory Surgery Maintenance Menu.

You may sort by clinic or procedure. When sorting by procedure, you may also include full procedure descriptions.

All reports provide the CPT code and procedure, a count of each procedure that has been entered for a clinic visit, number billed, the OPC status, and charge amount. The status and charge amount given are as of the current date. If no charge amount is shown, the procedure is not a billable procedure.

This output requires 132 column margin width.

Depending on the date range chosen, this report could be quite lengthy. You may wish to queue this to print during non-work hours.

The chart on the following page shows the prompts and steps involved in using the Most Commonly used Outpatient CPT Codes option.

Management Reports (Billing) Menu
Most Commonly used Outpatient CPT Codes

PROCESS
The following chart shows the prompts and steps involved in using the Most Commonly used Outpatient CPT Codes option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	CLINIC CPT USAGE REPORT Select one of the following: C CLINIC P PROCEDURE D PROCEDURE WITH EXTENDED DESCRIPTION Sort report by:	.C to sort by clinic .P to sort by procedure .D to sort by procedure with full procedure descriptions .<RET> or up-arrow <^>	2 2 2 7
2	Start with DATE:	.first date to include	3
3	Go to DATE:	.last date to include	4
	This prompt will repeat until a <RET> is entered. You are limited to 20 entries.		
4	Select division: ALL//	.<RET> to accept default .division name	5 4
	This prompt will repeat until a <RET> is entered. You are limited to 20 entries.		
5	Select clinic: ALL//	.<RET> to accept default .clinic name	6 5
6	You will be prompted for a device at this step. This report requires 132 columns.		
7	Return to the menu.		

Management Reports (Billing) Menu
Most Commonly used Outpatient CPT Codes

EXAMPLE

The following example shows what may appear on your screen while using this option followed by a sample output. User responses are shown in boldface type.

```
                              CLINIC CPT USAGE REPORT


     Select one of the following:

          C         CLINIC
          P         PROCEDURE
          D         PROCEDURE WITH EXTENDED DESCRIPTION

Sort report by: D  PROCEDURE WITH EXTENDED DESCRIPTION
Start with DATE: 1/1/91  (JAN 01, 1991)
Go to DATE: 1/1/92  (JAN 01, 1992)
Select division: ALL// <RET>
Select clinic: ALL// <RET>

This report requires 132 columns.
OUTPUT DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 132// <RET>
```

```
CLINIC CPT USAGE FOR JAN 1,1991 - JAN 1,1992                    APR 16, 1992  11:22   PAGE 1

ALL DIVISIONS AND CLINICS
AMBULATORY PROCEDURE                          COUNT  #BILLED  OPC STATUS                    CHARGE
-------------------------------------------------------------------------------------------------

10121  REMOVE FOREIGN BODY                      38      38   NATIONALLY ACTIVE             256.50
       INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES;
       COMPLICATED

11000  SURGICAL CLEANSING OF SKIN               56           NATIONALLY ACTIVE
       DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF
       BODY SURFACE

13152  REPAIR OF WOUND OR LESION                89      34   NATIONALLY ACTIVE             394.20
       REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 2.6 CM TO 7.5 CM

24925  AMPUTATION FOLLOW-UP SURGERY             29                                         394.20
       AMPUTATION, ARM THROUGH HUMERUS; SECONDARY CLOSURE OR SCAR REVISION

40654  REPAIR LIP                                1       1   NATIONALLY ACTIVE             394.20
       REPAIR LIP, FULL THICKNESS; OVER ONE HALF VERTICAL HEIGHT, OR
       COMPLEX

65235  REMOVE FOREIGN BODY FROM EYE             18      15   INACTIVE                       343.80
       REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM ANTERIOR CHAMBER OR LENS

66820  INCISION, SECONDARY CATARACT             36           NATIONALLY ACTIVE
       DISCISSION OF SECONDARY MEMBRANEOUS CATARACT (OPACIFIED POSTERIOR
       LENS CAPSULE AND/OR ANTERIOR HYALOID; STAB INCISION TECHNIQUE
       (ZIEGLER OR WHEELER KNIFE)

85102  BONE MARROW BIOPSY                       12           NATIONALLY ACTIVE
       BONE MARROW BIOPSY, NEEDLE OR TROCAR;
```

Management Reports (Billing) Menu
Clerk Productivity

INTRODUCTION

The Clerk Productivity option allows you to print a report for bills entered, authorized, or printed within a selected date range. The report is sorted alphabetically by the clerk who first entered, authorized, or printed the bill.

You may print either a full or summary report. If you print a full report, you may select specific clerk(s) and rate type(s) you wish to include.

A summary report will list the clerk, rate type, and the count and dollar amount of bills entered for each rate type for each clerk. A subtotal is provided for each clerk. The total amount for the report is also displayed.

The full report will list the clerk, rate type, date entered, current status, bill number, total charges, patient name, and patient ID for each bill included on the report. The full report should be printed at 132 column margin width.

Depending on the date range and other specifications you choose, this report could be quite lengthy. You may wish to queue the report to print during off hours.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Management Reports (Billing) Menu
Clerk Productivity

PROCESS
The following chart shows the prompts and steps involved in using the Clerk Productivity option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select one of the following: F FULL CLERK PRODUCTIVITY REPORT S SUMMARY OF CLERK PRODUCTIVITY REPORT Enter response:	.FULL .SUMMARY	2 2
2	Select one of the following: E WHO ENTERED BILL A WHO AUTHORIZED BILL P WHO FIRST PRINTED BILL REPORT BY WHICH CLERK FUNCTION:	.E - clerk who entered the bill .A - clerk who authorized the bill .P - clerk who first printed the bill	3 3 3
3	CLERK PRODUCTIVITY REPORT START WITH Date {Entered/ Authorized/First Printed}:	.date (bill was entered) to start report	4
	If you selected FULL at Step 1, you will proceed to Step 5. If you selected SUMMARY, you will proceed to Step 9.		
4	GO TO Date {Entered/ Authorized/First Printed}: ({date - date}): TODAY//	.date to end report .<RET> to accept default	5 or 9 5 or 9

Management Reports (Billing) Menu
Clerk Productivity

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
5	START WITH Clerk {Entered/ Authorized/First Printed} By: FIRST//	.<RET> to include all clerks	7
		.name of clerk to start report	6
6	GO TO Clerk {Entered/ Authorized/First Printed} By: LAST//	.<RET> to accept default	7
		.name of clerk to end report	7
7	START WITH Rate Type: FIRST//	.<RET> to accept default	9
		.first rate type you wish to include on report	8
8	GO TO Rate Type: LAST//	.<RET> to accept default	9
		.last rate type you wish to include on report	9
9	You will be prompted for a device at this step. A 132 column margin width is required.		
10	Return to the menu.		

Management Reports (Billing) Menu
Clerk Productivity

EXAMPLE
The following is an example of what might appear on the screen while using the Clerk Productivity option. User responses are shown in boldface type. An example of the output is provided on the following page.

```
     Select one of the following:

          F         FULL CLERK PRODUCTIVITY REPORT
          S         SUMMARY OF CLERK PRODUCTIVITY REPORT

Enter response: FULL CLERK PRODUCTIVITY REPORT

     Select one of the following:

          E         WHO ENTERED BILL
          A         WHO AUTHORIZED BILL
          P         WHO FIRST PRINTED BILL

REPORT BY WHICH CLERK FUNCTION: E  WHO ENTERED BILL

                              CLERK PRODUCTIVITY


Report requires 132 columns.
START WITH Date Entered:  6/1  (JUN 01, 1995)
GO TO Date Entered:  (6/1/93 - 11/26/93): TODAY// <RET>  (NOV 26, 1995)
  START WITH Clerk Entered By: FIRST// <RET>
    START WITH Rate Type: FIRST// <RET>
DEVICE: A100    HP LASER  RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

REQUESTED TIME TO PRINT: NOW// T@1700  (NOV 26, 1995@17:00)
REQUEST QUEUED!
Task number: 13021
```

Management Reports (Billing) Menu
Clerk Productivity

EXAMPLE, cont.

CLERK PRODUCTIVITY REPORT FOR JUN 1,1995 - NOV 26,1995 NOV 26,1995 13:02 PAGE 1

ENTERED/EDITED BY	RATE TYPE	DATE ENTERED	CURRENT STATUS	BILL NUMBER	TOTAL AMOUNT	NAME	PATIEN T ID
DERDERIAN,JOHN	REIMBURSABLE INS.	NOV 10,1995	ENTERED/NOT REV	N10026		GOBBELS,ANTHONY	0 96-44-3333
	REIMBURSABLE INS.	NOV 17,1995	ENTERED/NOT REV	N10032		HARRISON,GEORGE	712 -12-3035
	REIMBURSABLE INS.	NOV 17,1995	ENTERED/NOT REV	N10033		MORRISON,RODNEY	742-07-1250
SUBTOTAL					0.00		
SUBCOUNT				3			
HARPER,A	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10562		GREENE,NATHANAEL	213 -14-1867
	REIMBURSABLE INS.	SEP 7,1995	AUTHORIZED	L10563	5000.00	GREENE,N ATHANAEL	213-14-1867
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10564		SMITH,DON B.	011 -38-6551
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10565		COOPER ,BARNEY	712-12-1525
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10566		HARRISON,GEORGE	712 -12-3035
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10567		ANGE LO,MARK	722-09-0800
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10568		ROSENFIELD,SAM	732 -10-1542
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10569		DR UMMOND,JENNIFER KE	010-14-0440
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10570		HARTER,GLORIA	303 -03-1947
	REIMBURSABLE INS.	SEP 7,1995	ENTERED/NOT REV	L10571		LAMOUREUX,BILL	104-12-2340
	REIMBURSABLE INS.	NOV 23,1995	ENTERED/NOT REV	N10073		HARRISON,GEORGE	712 -12-3035
	REIMBURSABLE INS.	NOV 25,1995	ENTERED/NOT REV	N10074		DAVIDSON,JOHN	712-12-2040
SUBTOTAL					5000.00		
SUBCOUNT				12			
MOORE,CHARLES J.	REIMBURSABLE INS.	SEP 28,1995	ENTERED/NOT REV	L10681		MOORE,ZB	223 -34-4553
SUBTOTAL					0.00		
SUBCOUNT				1			
RASMUSSEN,PAUL	REIMBURSABLE INS.	SEP 10,1995	AUTHORIZED	L10676	163.00	EVERETT,MARGARET W	333 -77-6655
SUBTOTAL					163.00		
SUBCOUNT				1			
ROWE,LINDA	REIMBURSABLE INS.	JUN 10,1995	ENTERED/NOT REV	L10549		CASEY,BRENT	414 -56-5118
	REIMBURSABLE INS.	JUN 10,1995	ENTERED/NOT REV	L10550	163.00	REMSEN,CORNEL	209 -83-0983
SUBTOTAL					1 63.00		
SUBCOUNT				2			
THINER,ELIZABETH A	REIMBURSABLE INS.	SEP 15,1995	CANCELLED	L10677	163.00	ZIBRO,DENNIS	009 -78-6789
SUBTOTAL					163.00		
SUBCOUNT				1			
TOTAL					5489.00		
COUNT				20			

Management Reports (Billing) Menu
Rank Insurance Carriers By Amount Billed

INTRODUCTION The Rank Insurance Carriers By Amount Billed option is used to generate a listing of insurance carriers ranked by the total amount billed. You will be prompted for a date range from which bills should be selected and the number of carriers to be ranked.

Please note that insurance carriers which have been inactivated will be flagged as such on this report. If an inactivated company is associated with an active company to which all patients' policies have been recorded, the amount billed to the inactive company is credited to the active company.

This option no longer allows you to transmit the report to the MCCR Program Office. Now, your IRM Service has the capability to transmit the report electronically to the Program Office. A patch will be issued with specific instructions should this report be required to be transmitted.

Due to the brevity of this option, a process chart is not provided.

Management Reports (Billing) Menu
Rank Insurance Carriers By Amount Billed

EXAMPLE

The following is an example of what might appear on the screen while using the Rank Insurance Carriers By Amount Billed option. User responses are shown in boldface type. An example of the output is provided on the following page.

```
Select Management Reports (Billing) Menu Option:  Rank Insurance Carriers By
Amount Billed

      This report will generate a list of insurance carriers ranked by
      the total amount billed.  Please note that you may no longer opt
      to transmit this report to the MCCR Program Office in VACO using
      this option.

      You must select a date range in which bills to be used in the
      totals will be selected.

Enter Start Date on Bill Search: 10 1 93  (OCT 01, 1993)

Enter End Date on Bill Search: MAY  24, 1995// <RET>  (MAY 24, 1995)

Enter number of insurance carriers to rank: 30// 9

DEVICE: HOME// HALLWAY PRINTER     RIGHT MARGIN: 80// <RET>

DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// <RET>   (MAY 24, 1995@09:31:02)

This job has been queued as task #13251.
```

Management Reports (Billing) Menu
Rank Insurance Carriers By Amount Billed

Example, cont.

Ranking Of The Top 9 Insurance Carriers By Total Amount Billed

Facility: ALBANY (633) Run Date: 05/24/95
Date Range: 10/01/93 thru 05/24/95 Page: 1
** - denotes an inactive company

Rank		Insurance Carrier	Total Amt Billed
1.		HEALTH INSURANCE LTD. 23 3RD ST Suite 450 TROY, NEW YORK 12181	$215,868.78
2.		AETNA 123 Ave Of The Moons LOS ANGELES, CALIFORNIA 000 98	$35,843.63
3.	**	GHI 675 THIRD AVE TROY, NEW YORK 12345	$4,902.00
4.		AETNA 789 UBIQUITOUS STREET SALT LAKE CITY, UTAH 44432	$4,048.06
5.		AETNA 567 RAIN AVE. SIOUX CITY, IOWA 33321	$3,153.24
6.		PRUDENTIAL 123 MAIN STREET YORKVILLE, NEW YORK 33343	$2,862.43
7.		AETNA 123 MASON STREET NEW YORK, NEW YORK 11234	$1,576.00
8.		STRAIT INSURANCE 98 PARK AVE SAN ANTONIO, TEXAS 43222	$950.00
9.		TRAVELERS-RICHMOND 1234 THOMAS ST. RICHMOND, VIRGINIA 12345	$482.69

Total Amount Billed to all Ranked Carriers: $269,686.83

Management Reports (Billing) Menu
Billing Rates List

The Third Party Tortiously Liable rates have been removed from this report. These rates are now available on the Charge Item Report on the Print Charge Master option.

Introduction

The Billing Rates List option will print a list of billing rates for a selected date range. It is an efficient way to verify that all billing rate entries have been entered correctly.

The output generated by this option displays the CHAMPVA, Health Care Finance Administration (HCFA) ambulatory surgery rates, Medicare deductible, and copayments. The effective date, amount (basic rate), and additional amount will be shown for each rate, if applicable. Certain ambulatory surgeries may be billed at the HCFA rate. The amount shown (if any) in the "Additional Amount" column is an extra amount which may be charged for all procedures within that rate group. The amount shown under "Inpatient Per Diem" and "NHCU Per Diem" is the daily charge for Category C patients.

Any billing rate that is effective for any date within the selected range is displayed. If more than one rate was effective within the date range, both rates are displayed.

Management Reports (Billing) Menu
Billing Rates List

Example

```
Enter Beginning Date: 1/1  (JAN 01, 1997)
Enter Ending Date: t  (JUN 11, 1997)
DEVICE: HOME// <RET>  LAT    RIGHT MARGIN: 80// <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 1
                            Rates in effect from: JAN 01, 1997
                                              to: JUN 11, 1997
========================================= ===================================

CHAMPVA LIMIT
  Effective Date      Amount    Additional Amount
  OCT 01, 1991        $25

CHAMPVA SUBSISTENCE
  Effective Date      Amount    Additional Amount
  OCT 01, 1994        $9.50
HCFA AMB. SURG. RATE 1
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $285

HCFA AMB. SURG. RATE 2
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $382



Enter RETURN to continue or '^' to exit: <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 2
                            Rates in effect from: JAN 01, 1997
                                              to: JUN 11, 1997
================================================================================

HCFA AMB. SURG. RATE 3
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $438

HCFA AMB. SURG. RATE 4
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $539

HCFA AMB. SURG. RATE 5
  Effective Date      Amount    Additional  Amount
  JAN 01, 1992        $615

HCFA AMB. SURG. RATE 6
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $580      $200



Enter RETURN to continue or '^' to exit: <RET>
```

Management Reports (Billing) Menu
Billing Rates List

Example, cont.

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 3
                          Rates in effect from: JAN 01, 1997
                                            to: JUN 11, 1997
================================================ ==============================

HCFA AMB. SURG. RATE 7
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $853

HCFA AMB. SURG. RATE 8
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $705      $200

HCFA AMB. SURG. RATE 9
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $0

INPATIENT PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $10



Enter RETURN to continue or '^' to exit:

JUN 11,1997       ***Billing Rates Listing***                    PAGE 4
                          Rates in effect from: JAN 01, 1997
                                            to: JUN 11, 1997
================================================================================

MEDICARE DEDUCTIBLE
  Effective Date      Amount    Additional Amount
  JAN 01, 1996        $736

NHCU PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $5

NSC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1992        $2
  JUN 09, 1997        $5.00     $2.00

SC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $2


Enter RETURN to continue or '^' to exit:
```

Management Reports (Billing) Menu
Revenue Code Totals by Rate Type

INTRODUCTION

The Revenue Code Totals by Rate Type option prints the total amount billed by revenue code for a selected rate type and date range.

Circular 10-91-012 requires that revenue code 100 be used for the $10.00 hospital per diem and revenue code 550 be used for the $5.00 nursing home per diem. The purpose of this report is to allow sites to calculate the total amount billed for $5 (revenue code 550) and $10 (revenue code 100) Means Test per diems for input to AMIS segments 295 and 296.

You may print a list of all revenue codes (for the date range) with the associated patient name, patient ID, bill #, and individual amount or a summary list which provides the total amount and total number of bills for each code. It should be noted that because more than one revenue code may appear on a bill, the total number of bills does not equal the sum of the number of bills containing a specific revenue code.

The chart on the following page shows the steps and prompts involved in using this option.

Management Reports (Billing) Menu
Revenue Code Totals by Rate Type

PROCESS
The following chart shows the prompts and steps involved in using the Revenue Code Totals by Rate Type option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select Means Test Rate Type: MEANS TEST/CAT. C//	.<RET> to accept default	2
		.other rate type	2
		.<??> for rate type list	1
		.up-arrow <^>	6
2	START WITH DATE FIRST PRINTED:	.first date to include	3
3	GO TO DATE FIRST PRINTED:	.last date to include	4
4	PRINT SUMMARY PAGE ONLY? YES//	.<RET> to accept default and only print the summary	5
		.NO to print the complete list	5
5	You will be prompted for a device at this step.		6
6	Return to the menu.		

Management Reports (Billing) Menu
Revenue Code Totals by Rate Type

EXAMPLE
The following example shows what might appear on your screen when using the Revenue Code Totals by Rate Type option followed by a sample output. User responses are shown in boldface type.

```
Select Means Test Rate Type: MEANS TEST/CAT. C// <RET>   Who's Responsible:
PATIENT

START WITH DATE FIRST PRINTED: 6/1  (JUN 01, 1992)

GO TO DATE FIRST PRINTED: T  (JUN 03, 1992)

PRINT SUMMARY PAGE ONLY? YES// N  NO

Output Device: HOME// <RET>  Decnet    RIGHT MARGIN: 80// <RET>
```

```
Revenue Code Totals for MEANS TEST/CAT. C        JUN  3, 1992@15:34:31  PAGE 1
For Bills First Printed JUN  1, 1992  to  JUN  3, 1992
Patient               Pt. ID.        Bill No.          Rev. Code       Amo unt
-------------------------------------------------------------------------------
GRAY,MICHAEL          099-99-9978    L10068               510          $30.00

LYNCH,ANDREW          123-12-3432    L10069               100          $50.00

BROWN,ROBERT          009-23-8511    L10174               001         $652.00

BROWN,ROBERT          009-23-8511    L10203               550         $155.00

KAGAN,PETER           097-143-307    L10239               100         $150.00

MCBRIDE,WILLIAM       112-09-4435    L10489               550          $90.00

---------------------------------------------
REVENUE CODE TOTALS

Revenue Code: 001 .........         $652.00            1 Bills
Revenue Code: 100 .........         $200.00            2 Bills
Revenue Code: 510                    $30.00            1 Bills
Revenue Code: 550                   $245.00            2 Bills
                                ------------
                                  $1,127.00            6 Bills
```

Management Reports (Billing) Menu
Bill Status Report

INTRODUCTION

The Bill Status Report option is used to print a listing of bills and their status for a specified date range. You may choose to include all statuses or a single status. The report may be sorted by the event date (date beginning the bill's episode of care), bill date (date the bill was initially printed) or entered date (date the bill was first entered).

The following data items will be provided in the first portion of the report for each bill listed: bill number, patient name and patient ID#, event date, initials of the person who entered the bill, rate type, Means Test category, charges, and bill status with date of that status. If you choose to sort by bill date or entered date, the bills are grouped for each date (billed or entered) of the selected range. The second portion of the report provides summary totals. The dollar amount and total number of bills for each bill type and for each status are included. Grand totals are also provided.

For bills which have been disapproved during the authorization process, the report will show *REVIEWED/ DISAPP (will appear only for bills prior to this version of the IB software) or *AUTHORIZED/DISAPP after the status. The bill status will be followed by the initials of the user responsible for that status and his/her DUZ number. This is a number which uniquely identifies the user to the system. If a bill is pending (i.e., not printed or cancelled), the bill status will be preceded by an asterisk (*) on the report.

The chart on the following page shows the prompts and steps involved in using the Bill Status Report option.

Management Reports (Billing) Menu
Bill Status Report

PROCESS
The following chart shows the prompts and steps involved in using the Bill Status Report option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH	THEN STEP
1	DO YOU WANT TO PRINT THE STATUS OF ALL BILLS? YES//	.<RET> to accept default .NO .up-arrow <^>	3 2 6
2	CHOOSE A BILL STATUS:	.desired status .<?> for list of statuses	3 2
3	Select one of the following: 1 EVENT DATE 2 BILL DATE 3 ENTERED DATE SORT BY: 1//	.<RET> or 1 to sort by the date beginning the bill's episode of care .2 - to sort by the date the bill was initially printed .3 - to sort by the date the bill was first entered	4 4 4
4	Start with {Event/Bill/ Entered} DATE:	.date with which to start report	5
5	Go to {Event/Bill/ Entered} DATE: TODAY//	.<RET> to accept default .date to end report	6 6
6	"*** Margin width of this output is 132 ***" You will be prompted for a device at this Step.		7
7	Return to the menu.		

Management Reports (Billing) Menu
Bill Status Report

EXAMPLE
The following example shows what might appear on the screen while using the Bill Status Report option. User responses are shown in boldface type. An example of the output produced by this option is provided on the following page.

```
DO YOU WANT TO PRINT THE STATUS OF ALL BILLS? YES// <RET>   (YES)

     Select one of the following:

          1         EVENT DATE
          2         BILL DATE
          3         ENTERED DATE

SORT BY: 1// <RET>  EVENT DATE

Start with Event DATE: 6-1-93  (JUN 1, 1993)
Go to Event DATE: TODAY// 6-16-93  (JUN 16, 1993)

*** Margin width of this output is 132 ***

DEVICE: HOME// HALLWAY PRINTER       RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y   (YES)

Requested Start Time: NOW// <RET>   (DEC 16,1993@09:55)

Request Queued!
```

Management Reports (Billing) Menu
Bill Status Report

EXAMPLE, cont.

Date/Time Printed: DEC 16,1993@09:14
Medical Care Cost Recovery Bill Status Report for period covering JUN 1, 1993 through JUN 16, 1993 Page 1

BILL NO.	PATIENT NAME	PT.ID	EVENT DATE	ENTRD BY	RATE TYPE	MT CATEGORY	CHARGES	BILL STATUS
L10574	SMITH,THOMAS	8912	06/01/93	ARH	REIM INS-OPT	N/A	$936.40	* AUTHORIZED 09/07/93 (ARH/10869)
L10651	LAMOUREUX,MARK I	6969	06/02/93	ARH	REIM INS-OPT	A	$442.20	* AUTHORIZED 09/07/93 (ARH/10869)
L10647	CANNEDY,JOE	2020	06/03/93	ARH	MT/CAT C-OPT	N/A	$30.00	PRINTED 09/07/93 (ARH/10869)
N10046	GAVIN,MAC	9087	06/03/93	ARH	REIM INS-OPT	R	$633.10	PRINTED 11/19/93 (ARH/10869)
L10660	WALKER,LUKE	8956	06/04/93	ARH	REIM INS-OPT	N/A	$623.60	* AUTHORIZED 09/07/93 (ARH/10869)
L10620	DERDERIAN,WALKER	2040	06/07/93	ARH	REIM INS-OPT	N/A	$0.00	* ENTERED 09/07/93 (ARH/10869)
L10648	SPINNER,JOHN	5545	06/07/93	ARH	CRIME-OPT	N/A	$0.00	* AUTHORIZED 09/07/93 (ARH/10869)
L10601	KILMADE,MICHAEL J	2123	06/09/93	ARH	REIM INS-OPT	N	$150.00	* ENTERED 09/07/93 (ARH/10869)
L10632	WARREN,STEPHEN	1542	06/09/93	ARH	REIM INS-OPT	A	$128.00	* ENTERED 09/07/93 (ARH/10869)
L10549	CASEY,BRENT	5118	06/10/93	LR	REIM INS-OPT	N/A	$491.80	* ENTERED 06/10/93 (LR/700)

* Denotes that the bill status is not Printed or Cancelled

Date/Time Printed: DEC 16,1993@09:14
Medical Care Cost Recovery Bill Status Report for period covering JUN 1, 1993 through JUN 16, 1993 Page 2

REPORT STATISTICS

CRIME-OPT	.....	$0.00	1 BILLS
MT/CAT C-OPT	.....	$30.00	1 BILLS
REIM INS-OPT	.....	$3,405.10	8 BILLS
		$3,435.10	10 BILLS
AUTHORIZED	.....	$2,002.20	4 BILLS
ENTERED	.....	$769.80	4 BILLS
PRINTED	.....	$663.10	2 BILLS
		$3,435.10	10 BILLS

Management Reports (Billing) Menu
Rate Type Billing Totals Report

INTRODUCTION

The Rate Type Billing Totals Report option is used to obtain a listing of all billing totals for each rate type for a specified date range. The date range is selected by event date (the date beginning the bill's episode of care) or bill date (the date the bill was initially printed).

The report is generated in two sections. The first section divides all the bills for each rate type (Category C, Workman's Compensation, Tort Feasor, etc.) into the following categories: initiated, pending, printed, and cancelled. The exact number of bills and dollar amount for each category is provided. The total amounts (sum of all rate types) are also given for each category.

The second section of the report is a breakdown of all the pending billing records (the "pending" category in the first section). All the pending bills for each rate type are divided into the following categories: no action, reviewed, and authorized. The exact number of bills and the dollar amount for each category is provided. The total amounts (sum of all rate types) are also given for each category.

The margin width of this output is 132.

Due to the brevity of this option, a process chart has not been provided.

Management Reports (Billing) Menu
Rate Type Billing Totals Report

EXAMPLE
The following is an example of what might appear on the screen while using the Rate Type Billing Totals Report option. User responses are shown in boldface type. An example of the output produced by this option is provided on the following page.

```
 Select one of the following:

          1         EVENT DATE
          2         BILL DATE

SELECT BILLS BY: 1// <RET>
Start with EVENT DATE:  1-3-88   (JAN 03, 1988)
Go to DATE:  3-1-88   (MAR 01, 1988)

*** Margin width of this output is 132 ***

DEVICE:  HALLWAY PRINTER            RIGHT MARGIN: 132//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  Y   (YES)

Requested Start Time: NOW//  <RET>   (JUL 14,1988@07:46)

Request Queued!
```

Management Reports (Billing) Menu
Rate Type Billing Totals Report

EXAMPLE, cont.

Date/Time Printed: JUL 14,1988@07:46

Billing Summary Report for period covering JAN 3,1988 through MAR 1,1988 (by Event Date)

	INITIATED		PENDING		PRINTED		CANCELLED	
BILL TYPE	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars
CRIME VICTIM	0	$0.00	0	$0.00	0	$0.00	0	$0.00
DENTAL	1	$127.00	0	$0.00	0	$0.00	1	$127.00
HUMANITARIAN	1	$0.00	1	$0.00	0	$0.00	0	$0.00
INTERAGENCY	1	$7,200.00	0	$0.00	1	$7,200.00	0	$0.00
MEANS TEST/CAT. C	13	$11,964.00	8	$11,284.00	4	$160.00	1	$ 520.00
MEDICARE ESRD	1	$124,900.00	1	$124,900.00	0	$0.00	0	$0.00
NO FAULT INS.	0	$0.00	0	$0.00	0	$0.00	0	$0.00
REIMBURSABLE INS.	20	$138,852.00	6	$ 12,190.00	8	$102,985.00	6	$23,677.00
SHARING AGREEMENT	0	$0.00	0	$0.00	0	$0.00	0	$0.00
TORT FEASOR	0	$0.00	0	$0.00	0	$0.00	0	$0.00
UNKNOWN	0	$0.00	0	$0.00	0	$0.00	0	$0.00
WORKERS' COMP.	1	$2,250.00	0	$0.00	1	$2,250.00	0	$0.00
TOTALS	38	$285,293.00	16	$148,374.00	14	$112,595.00	8	$24,324.00

Date/Time Printed: JUL 14,1988@07:46

Summary of Pending Bill Authorizations for period covering JAN 3 ,1988 through MAR 1,1988 (by Event Date)

	TOTAL PENDING		NO ACTION		REVIEWED		AUTHORIZED	
BILL TYPE	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars
CRIME VICTIM	0	$0.00	0	$0.00	0	$0.00	0	$0.00
DENTAL	0	$0.00	0	$0.00	0	$0.00	0	$0.00
HUMANITARIAN	1	$0.00	1	$0.00	0	$0.00	0	$0.00
INTERAGENCY	0	$0.00	0	$0.00	0	$0.00	0	$0.00
MEANS TEST/CAT. C	8	$11,284.00	3	$0.00	0	$0.00	5	$11,284.00
MEDICARE ESRD	1	$124,900.00	1	$124,900.00	0	$0.0 0	0	$0.00
NO FAULT INS.	0	$0.00	0	$0.00	0	$0.00	0	$0.00
REIMBURSABLE INS.	6	$12,190.00	2	$0.00	3	$12,140.00	1	$50.00
SHARING AGREEMENT	0	$0.00	0	$0.00	0	$0.00	0	$0.00
TORT FEASOR	0	$0.00	0	$0.00	0	$0.00	0	$0.00
UNKNOWN	0	$0.00	0	$0.00	0	$0.00	0	$0.00
WORKERS' COMP.	0	$0.00	0	$0.00	0	$0.00	0	$0.00
PENDING TOTALS	16	$148,374.00	7	$124,900.00	3	$12,140.00	6	$11,334.00

Management Reports (Billing) Menu
Insurance Payment Trend Report

INTRODUCTION

This option allows you to analyze payment trends among insurance companies and track receivables which are due your facility. Many different criteria may be specified to limit the selection of bills such as rate type, inpatient or outpatient bills, open or closed bills, treatment dates, bill printed dates, and insurance companies.

The report may be run for a single insurance company or a range of companies. In addition, the user may analyze any specialized subset of bills by selecting an additional field from the BILL/CLAIMS file (#399) and specifying a range of values for that field.

You have the option to run a detailed report for all claims which meet the report criteria, or to print summary statistics only. The detailed report includes the bill number, patient name and age (as of the bill event date), bill from and to dates, date the bill was printed (authorized), date the bill closed, the number of days the bill has been open (the difference between the DATE PRINTED and the DATE BILL CLOSED fields), the amounts billed, collected, unpaid, remaining open, and percentage collected. The AMOUNT PENDING column has been added to differentiate the number of unpaid dollars and the number of dollars which are still pending collection. If the bill is not closed, the amount pending is the same as the amount unpaid. If the bill is closed (signified by an asterisk next to the bill number), the amount pending is zero.

The report is sorted alphabetically by insurance company name and a subtotal for number of bills, amount billed, amount collected, amount unpaid, amount pending, and percentage collected is given for each company. If you choose only to print summary statistics, only these subtotals are printed. Also included, for either the detailed or summary report, are the grand totals for these categories. A margin width of 132 cols. is required for this output.

The DATE BILL CLOSED field will always have an entry. If the bill is not actually closed, the Accounts Receivable status of the bill will appear on the report in the DATE BILL CLOSED column. If a bill is closed, an asterisk (*) will appear after the bill number.

Management Reports (Billing) Menu
Insurance Payment Trend Report

INTRODUCTION cont. The chart beginning on the following page shows the prompts and steps involved in using the Insurance Payment Trend Report option.

Management Reports (Billing) Menu
Insurance Payment Trend Report

PROCESS

The following chart shows the prompts and steps involved in using the Insurance Payment Trend Report option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select RATE TYPE NAME:	.rate type	2
		.<??> for a list	1
		.<RET> or up-arrow <^>	18
2	"You may select a field from the BILL/CLAIMS file which you may use to limit the selection of records to appear on the report."		
	Do you wish to choose such a field? NO//	.YES	3
		.<RET> to accept default	6
3	Select BILL/CLAIMS FIELD:	.field number or name from the BILLS/CLAIMS file	4
		.<??> for a list	3

Enter an <@> at Steps 4 and 5 to include only those records with null values in the selected BILL/CLAIMS field. Enter an <@> at Step 4 and a <RET> or a value at Step 5 to include all records with null values plus all other records from FIRST to whatever your entry at Step 5 indicates.

On-line documentation regarding the specific selected field may be accessed by entering <??> at Steps 4 and 5. This help is provided to give you a description of the field. Please disregard any instruction regarding entries other than the indented text at the end of the message.

4	START WITH {field name}: FIRST//	.<RET> to accept default	5
		.the first field value you wish to include	5
		.<@> to include null values (see above note)	5
		.<??> for on-line documentation (see above note)	4

Management Reports (Billing) Menu
Insurance Payment Trend Report

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
5	GO TO {field name}: LAST//	.<RET> to accept default	6
		.the last field value you wish to include	6
		.<@> to include null values (see note at Step 4)	6
		.<??> for on-line documentation (see note at Step 4)	5
6	Select (I)NPATIENT, (O)UTPATIENT, or (B)OTH BILL RECORDS: BOTH//	.<RET> to accept default and include both inpatient and outpatient bills	7
		.INPATIENT to include only inpatient bills	8
		.OUTPATIENT to include only outpatient bills	8
7	Print a (C)ombined or (S)eparate Reports: C//	.<RET> to accept default and print a combined report	8
		.SEPARATE to print separate inpatient and outpatient reports	8
8	Select (O)PEN, (C)LOSED, or (B)OTH TYPES OF BILLS: BOTH//	.<RET> to accept default and print both open and closed bills	9
		.OPEN bills only	9
		.CLOSED bills only	9

Management Reports (Billing) Menu
Insurance Payment Trend Report

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
9	Print Report by (1) DATE BILL PRINTED or (2) TREATMENT DATE: 1//	.<RET> or 1 to print by date the bill was generated	10
		.2 to print by the date the patients received treatment	10
10	START WITH {DATE BILL PRINTED/TREATMENT DATE}:	.the first date you wish to include on the report	11
11	GO TO {DATE BILL PRINTED/ TREATMENT DATE}:	.the last date you wish to include on the report	12
12	Run report for a (S)INGLE Insurance Company or a (R)ANGE: RANGE//	.<RET> or <R>ANGE	14
		.<S>INGLE	13
13	Select INSURANCE COMPANY:	.insurance company name	16
	Enter an <@> at Steps 14 and 15 to include only those records with null values. Enter an <@> at Step 14 and a <RET> or a value at Step 15 to include all records with null values plus all other records from FIRST to whatever your entry at Step 15 indicates.		
14	START WITH INSURANCE COMPANY: FIRST//	.<RET> to accept default	15
		.insurance company you wish to begin report with	15
		.<@> to include null values (see above note)	15
15	GO TO INSURANCE COMPANY: LAST//	.<RET> to accept default	16
		.insurance company you wish to end report with	16
		.<@> to include null values (see note at Step 13)	16

Management Reports (Billing) Menu
Insurance Payment Trend Report

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
16	Do you wish to print summary statistics only?	.<Y>ES	17
		.<N>O	17
17	"You will need a 132 column printer for this report!" You will be prompted for a device at this Step.		18
18	Return to the menu.		

Management Reports (Billing) Menu
Insurance Payment Trend Report

EXAMPLE
Following is an example of what might appear on the screen while using this option. User responses are shown in boldface type. Sample outputs are also shown.

```
Select RATE TYPE NAME: 8  REIMBURSABLE INS.     Who's Responsible: INSURER

You may select a field from the BILL/CLAIMS file which you may use
to limit the selection of records to appear on the report.

Do you wish to choose such a field? NO// YES
Select BILL/CLAIMS FIELD: DISCHARGE STATUS
   START WITH DISCHARGE STATUS: FIRST// <RET>
   GO TO DISCHARGE STATUS: LAST// <RET>
Select (I)NPATIENT, (O)UTPATIENT, or (B)OTH BILL RECORDS: BOTH// <RET>  BOTH
Print a (C)ombined or (S)eparate Reports: C// <RET>  COMBINED
Select (O)PEN, (C)LOSED, or (B)OTH TYPES OF BILLS: BOTH// <RET>  BOTH

Print Report by (1) DATE BILL PRINTED or (2) TREATMENT DATE: 1// <RET>  DATE
BILL PRINTED
   START WITH DATE BILL PRINTED: 1/1/92  (JAN 01, 1992)
   GO TO DATE BILL PRINTED: 3/4/92  (MAR 04, 1992)

   Run report for a (S)INGLE Insurance Company or a (R)ANGE: RANGE// <RET>
RANGE

      START WITH INSURANCE COMPANY: FIRST// <RET>
      GO TO INSURANCE COMPANY: LAST// <RET>

Do you wish to print summary statistics only? Y  YES

You will need a 132 column printer for this report!
DEVICE:  LASER PRINTER            RIGHT MARGIN: 132//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>
```

Management Reports (Billing) Menu
Insurance Payment Trend Report

EXAMPLE, cont.

Output for a Range of Insurance Companies.

```
REIMBURSABLE INS. PAYMENT TREND REPORT  --  COMBINED INPATIENT AND OUTPATIENT BILLING            NOV 26, 1993   PAGE: 1
      DATE BILL PRINTED:  01/01/92  -  03/04/92          Note: '*' after the Bill Number denotes a CLOSED bill
      DISCHARGE STATUS:  ALL VALUES
BILL      PATIENT                                    DATE     DATE BILL   #     AMOUNT   AMOUNT      AMOUNT   AMOUNT    PERCENT
NUMBER    NAME/ (AGE)            BILL FROM  -  TO    PRINTED    CLOSED    DAYS   BILLED  COLLECTED    UNPAID   PENDING   COLLECTED
-------------------------------------------------------------------------------------------------------------------------------------

        PRIMARY INSURANCE CARRIER:  AETNA
                                    123 AVE OF THE MOONS
                                    LOS ANGELES, CALIFORNIA   00098               Phone: 618-567-9871

L10042    WARNER,TERRY (49)       02/07/92  02/07/92  02/07/92  NEW BILL    658    200.00    100.00     100.00    100.00    50.00
                                                                                  --------- ---------  --------- ---------  --------
TOTAL NUMBER OF BILLS:  1                                                          200.00    100.00     100.00    100.00    50.00


        PRIMARY INSURANCE CARRIER:  AETNA
                                    789 UBIQUITOUS STREET
                                    SALT LAKE CITY, UTAH   44432

L10030    KIK,MOLLY K (33)        04/09/91  04/14/91  02/06/92  NEW BILL    659   2770.00      0.00    2770.00   2770.00     0.00
                                                                                  --------- ---------  --------- ---------  --------
TOTAL NUMBER OF BILLS:  1                                                         2770.00      0.00    2770.00   2770.00     0.00


        PRIMARY INSURANCE CARRIER:  STRAIT INSURANCE
                                    98 PARK AVE
                                    SAN ANTONIO, TEXAS   43222

L10029(*) SKINNER,SANDRA  (45)    02/05/91  02/05/91  02/18/92  11/26/93    647    950.00    702.50     247.50      0.00    75.00
                                                                                  --------- ---------  --------- ---------  --------
TOTAL NUMBER OF BILLS:  1                                                          950.00    702.50     247.50      0.00    75.00


      GRAND TOTAL NUMBER OF BILLS:            3
      GRAND TOTAL AMOUNT BILLED:        3920.00
      GRAND TOTAL AMOUNT COLLECTED:      802.50
      GRAND TOTAL AMOUNT UNPAID:        3117.50
      GRAND TOTAL AMOUNT PENDING:       2870.00
      PERCENTAGE COLLECTED:               20.47
```

Output for a Single Insurance Company.

```
REIMBURSABLE INS. PAYMENT TREND REPORT  --  COMBINED INPATIENT AND OUTPATIENT BILLING            SEP 27, 1995   PAGE: 1
      DATE BILL PRINTED:  01/01/95  -  09/27/95          Note: '*' after the Bill Number denotes a CLOSED bill
BILL      PATIENT                                  DATE     DATE BILL  #      AMOUNT    AMOUNT     AMOUNT    AMOUNT    PERC
NUMBER    NAME/ (AGE)          BILL FROM  -  TO    PRINTED    CLOSED   DAYS    BILLED   COLLECTED    UNPAID    PENDING   COLL
-------------------------------------------------------------------------------------------------------------------------------

      PRIMARY INSURANCE CARRIER:  AETNA
                                  123 AVE OF THE MOONS
                                  LOS ANGELES, CALIFORNIA  00098         Phone: 618-567-9871

L01226    ADAMS,JOHN (70)       06/22/95  07/10/95  09/20/95   NEW BILL    1      194.00       0.00     194.00     194.00   0.00
L01227    ADAMS,JOHN (70)       07/17/95  07/31/95  09/20/95   NEW BILL    1      194.00       0.00     194.00     194.00   0.00
L00381    MOORE,STEPHEN (46)    01/01/92  07/02/92  03/28/95   NEW BILL  177     4460.00       0.00   446 0.00    4460.00   0.00
L00823    WEST,JAMES (68)       10/22/93  10/22/93  03/15/95   NEW BILL  190      178.00       0.00     178.00     178.00   0.00
                                                                            ----------  ---------  --------  ---------  -----
TOTAL NUMBER OF BILLS:  4                                                    5026.00       0.00    5026.00    5026.00   0.00


      GRAND TOTAL NUMBER OF BILLS:          4
      GRAND TOTAL AMOUNT BILLED:      5026.00
      GRAND TOTAL AMOUNT COLLECTED:      0.00
      GRAND TOTAL AMOUNT UNPAID:      5026.00
      GRAND TOTAL AMOUNT PENDING:     5026.00
      PERCENTAGE COLLECTED:              0.00
```

Management Reports (Billing) Menu
Unbilled BASC for Insured Patient Appointments

INTRODUCTION

The Unbilled BASC for Insured Patient Appointments report lists all BASC (billable ambulatory surgical code) procedures for scheduled appointments of insured patients that could not be matched with BASC procedures entered on a bill for the patient for a selected date range. The match is based on the appointment date in Scheduling and the procedure date in Billing. The purpose of this report is to find all CPTs that were entered in Scheduling but never brought into Billing.

The list is printed in alphabetical order by patient name and provides the patient ID, appointment date, CPT code, and procedure.

Due to the brevity of this option no process chart is provided.

Management Reports (Billing) Menu
Unbilled BASC for Insured Patient Appointments

EXAMPLE

The following example shows what might appear on the screen while using this option followed by a sample output. User responses are shown in boldface type.

```
                Report Unbilled BASC for Insured Patient Appointments


Start with DATE: 3/1  (MAR 01, 1992)
Go to DATE: 3/31  (MAR 31, 1992)

Report requires 132 columns.
OUTPUT DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

PATIENT NAME	PATIENT ID	APPOINTMENT DATE	BILLABLE AMBULATORY PROCEDURE
BROWN,WILLIAM	009-83-8510	MAR 27,1992	15950 REMOVE THIGH PRESSURE SORE
			15951 REMOVE THIGH PRESSURE SORE
LEIFER,BRAD	442-09-8879	MAR 3,1992	85102 BONE MARROW BIOPSY
MOORE,ROBERT	097-25-5657	MAR 7,1992	11042 CLEANSING OF SKIN/TISSUE
MOORE,ROBERT	097-25-5657	MAR 13,1992	24925 AMPUTATION FOLL OW-UP SURGERY
PETER,JOHN	112-53-1190	MAR 25,1992	12006 REPAIR SUPERFICIAL WOUND(S)
REIGNS,STEPHEN	667-43-3534	MAR 24,1992	15950 REMOVE THIGH PRESSURE SORE
			15951 REMOVE THIGH PRESSURE SORE
SPINNER,RAYMOND	132-12-1211	MAR 1,1992	10121 REMOVE FOREIGN BODY

Medication Copayment Income Exemption Menu
Print Charges Canceled Due to Income Exemption

INTRODUCTION

This option enables you to print a report which lists patients and medication copayment charges that are cancelled due to the income exemption (charges to patients determined to be exempt from the medication copayment requirement).

You are prompted for a date range. The "start date" defaults to the effective date of the medication copayment legislation (Public Law 102-568), October 30, 1992, and the "to date" defaults to the date of the conversion completion.

This report should be reconciled periodically with the Accounts Receivable Medication Co-Pay Exemption Report (Medication Co-Pay Exemption Report option) to insure accuracy of patients' accounts.

Initially, this report will print a list of charges cancelled during the installation/conversion process. Later, this report may be used to list charges automatically cancelled. This occurs when a patient with a status of NON-EXEMPT due to no income data becomes EXEMPT due to income below the threshold level.

This report includes the patient name and ID, prescription date and number, cancel date and IB number, bill number and amount, a patient count, and dollar total. You may also print a Conversion Quick Status Report with the listing which includes data such as the dates the conversion started and completed, total number of patients checked, number of patients exempt and non-exempt, the number of bills checked, dollar amount checked, total bills cancelled, and amount cancelled.

You may wish to queue this report to print during non-work hours as it may be very lengthy. The output for this option requires 132 columns.

Due to the brevity of this option, no process chart is provided.

Medication Copayment Income Exemption Menu
Print Charges Canceled Due to Income Exemption

EXAMPLE

The following example shows what might appear on your screen when using this option followed by a sample output. User responses appear in boldface type.

```
Medication Copayment Charges Retroactively Canceled


Start with DATE: OCT 30, 1992// <RET> (OCT 30, 1992)

Go to DATE: FEB  4, 1993// <RET> (FEB 04, 1993)

Print Conversion Quick Status Report with listing? NO// YES

You will need a 132 column printer for this report!

DEVICE: HOME// A137/10/6/UP  HP LASER     RIGHT MARGIN: 80// 132
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// T@1800
```

```
               Medication Copayment Exemption Conversion Status

Conversion was started on:   FEB  4, 1993@11:18:28
The conversion completed on: FEB  4, 1993@18:19:01
Elapse time for Conversion was: 7 Hours,  0 Minutes,  33 Seconds

            Last Patient DFN Checked  ==        91

  1.          Total Patients Checked  ==        7455
                     Exempt Patients  ==        2069
                 Non-Exempt Patients  ==        5386

  2. Total Number of Bills checked    ==       36 568
                Dollar Amount Checked  == $     86252
         No. of Exempt Bills Checked  ==        14218
                  Exempt Dollar amount  == $     33426
     No. of Non-Exempt Bills Checked  ==        22350
            Non-exempt Dollar amount  == $      52826

  3.   Total Bills Actually canceled  ==        14113
            Amount Actually canceled  == $     33158
```

Medication Copayment Income Exemption Menu
Print Charges Canceled Due to Income Exemption

EXAMPLE, cont.

```
Rx Copay Income Exemption Report                                  MAR  4, 1993 11:18:43  Page 1
                                                        Cancel     Cancel       Original
Name               Pt. ID        Rx Date   Rx/Refill  Date       IB Number    Bill No.      Amount
-------------------------------------------------------------------------------------------------
KAGEN,PETER        088-44-0999  02/01/93    100146    02/02/93   500210       500-P30048      $2
                                02/01/93    100147    02/02/9 3  500211       500-P30048      $2
                                                                                --------------
                                                                               Count  =     2
                                                                               Amount = $   4

ALLEN,THOMAS       101-02-0211  01/26/93    100037/1  01/27/93   500157       500-P30014     $4
                                01/26/93    1003      01/27/93   500158       500-P30014     $2
                                                                                --------------
                                                                              Count  =     2
                                                                              Amount = $   6

HART,KEVIN         111-02-0122  01/26/93    100045    01/27/93   500155       500-P30016     $2
                                01/26/93    100045/1  01/27/93   500156       500-P30016     $2
                                                                                --------------
                                                                              Count  =     2
                                                                              Amou nt = $   4


                                    ====================================
                                        Total Patient Count =       3
                                        Total Rx Count      =       6
                                        Total Dollar amount = $    14
```

Medication Copayment Income Exemption Menu
Edit Copay Exemption Letter

INTRODUCTION This option allows you to edit IB form letters. You are first prompted to edit the HEADER field. This text is automatically centered at the top of the letter (it is not necessary for you to center them), and must be edited to your facility's name and address. You are limited to six lines of text.

The second field, the MAIN BODY, contains the text of the letter including the signer's title. Because the person signing this letter may be site specific, it might be necessary to edit the signer's title.

The default for the starting address line (patient address) is 15. This may be edited to any number between 10 and 25. This feature is provided to account for slight differences in printers and automated letter folders at each site.

When editing the IB Income Test Reminder letter you are also prompted for a reprint date, whether or not to exclude domiciliary patients, and to schedule the days on which you want the letters to print. The days you select to print the letters actually represent the mornings you want to pick up the letters from the printer. For example, if you choose Monday the letters actually print Sunday evening and are ready to be picked up on Monday morning. You can also prevent the letters from being printed by answering YES to the "Do you wish to stop this job from running?" prompt.

After editing is completed, you can test print one letter. If you choose to test print, you are prompted to select a patient and device. The letter is queueable to any printer.

Due to the brevity of this option, no process chart is provided.

Medication Copayment Income Exemption Menu
Edit Copay Exemption Letter

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses appear in boldface type. A sample letter is also provided.

```
Edit Exemption Patient Notification Letter


Select IB FORM LETTER NAME:    IB INCOME TEST REMINDER
HEADER:
  1>Department of Veterans Affairs Medical Center
  2>113 Holland Avenue
  3>Albany, New York   12208
  4>
  5>
  6>
EDIT Option: <RET>
MAIN BODY:. . .
       . . .
 10>To update your income information so we may  review your
 11>copayment exemption status, please call 462-3311 x9372
 12>to set up an appointment to provide us with current
 13>income information.
 14>
 15>
 16>John Smith
 17>
 18>Chief, MAS
Edit line: 16
 16>John Smith
  Replace ... With Jane Reynolds  Replace <RET>
   Jane Reynolds
Edit line: <RET>
EDIT Option: <RET>
STARTING ADDRESS LINE: 15// <RET>
LETTER DEVICE: A400-10/6/UP// <RET>
REPRINT DATE: <RET>
EXCLUDE DOM PATIENTS: N  NO

The income test reminder letters are scheduled to be printed on:

        MONDAY
        WEDNESDAY
        FRIDAY

Do you wish to stop this job from running? N  NO
```

Medication Copayment Income Exemption Menu
Edit Copay Exemption Letter

EXAMPLE, cont.

```
Your printed letters may be picked up on the following mornings:

        0   SUNDAY
        1   MONDAY
        2   TUESDAY
        3   WEDNESDAY
        4   THURSDAY
        5   FRIDAY
        6   SATURDAY

    Select, by number, those mornings to pick up letters:  (0-6): ^


Test Print Letter? YES// <RET>

Select BILLING PATIENT:  KAGAN,PETER          03-02-45     342957333     NO
     NSC VETERAN
DEVICE: HOME// A138 -10/6/UP  KYOCERA RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

Medication Copayment Income Exemption Menu
Edit Copay Exemption Letter

EXAMPLE, cont.

Department of Veterans Affairs Medical Center
113 Holland Avenue
Albany, New York 12208

DEC 14, 1995

In Reply Refer To:
342-95-7333

PETER KAGAN
54 BROADWAY
BOSTON, MA 04443

The VA is required by law to charge veterans who receive medications on an outpatient basis for the treatment of nonservice-connected conditions, a copayment of $2.00 for each 30-day (or less) supply of medication provided. Based on the income information requested each year, some veterans may be exempt from the copayment.

Our records indicate that your medication copayment exemption status will expire on December 31, 1995.

To update your income information so we may review your copayment exemption status, please call 462-3311 x9372 to set up an appointment to provide us with current income information.

Jane Reynolds

Chief, MAS

Medication Copayment Income Exemption Menu
Inquire to Medication Copay Income Exemptions

INTRODUCTION

This option allows you to print a brief or full inquiry of exemptions for a patient. The brief inquiry is used to view past and/or present exemptions, and the full inquiry is used to view the entire audit history of all changes to a patient's exemption status.

Both inquiries provide the patient name and current status. The brief inquiry provides the following information on all active exemptions for the selected patient: effective date, type, status, reason, how the entry was added, and when. The full inquiry provides the following information for each exemption for the patient: effective date, status, whether active or inactive, how the entry was added, by whom and when, type, and reason for exemption.

Due to the brevity of this option, no process chart is provided.

NOTE TO PROGRAMMERS
For users whose FileMan Access ="@" (DUZ(0)="@"), the full inquiry feature will display the patient internal entry number and the billing exemption internal entry number to aid in problem resolution.

Medication Copayment Income Exemption Menu
Inquire to Medication Copay Income Exemptions

EXAMPLE

The following example shows what might appear on your screen when using this option followed by a sample output. User responses appear in boldface type.

```
Select BILLING PATIENT:  ALLEN,THOMAS         NON-EXEMPT     INCOME>PENSION 01-01-44
324337511     NSC VETERAN
(B)rief or (Full) Inquiry: Brief// FULL
DEVICE: HOME// A137/10/6/UP  HP LASER           RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)


Billing Exemption Inquiry              MAR  5, 1993 13:10:46   Page 1
KAGEN,PETER        7511        Currently: NON-EXEMPT-INCOME>PENSION   02/10/93
-------------------------------------------------------------------------------
  Effective Date: FEB 10, 1993           Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT           Reason: NO INCOME DATA
          Active: NO, INACTIVE           User: ALLEN,MICHAEL
       How Added: SYSTEM           When Added: FEB 10, 1993@15:14:12

  Effective Date: FEB 10, 1993           Type: COPAY INCOME EXEMPTION
          Status: EXEMPT               Reason: HARDSHIP
          Active: NO, INACTIVE           User: ALLEN,MICHAEL
       How Added: MANUAL           When Added: FEB 11, 1993@09:17:06
Charges Canceled: FEB 10, 1993             To: FEB 11, 1993

  Effective Date: FEB 10, 1993           Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT           Reason: INCOME>PENSION
          Active: NO, INACTIVE           User: ALLEN,MICHAEL
       How Added: SYSTEM           When Added: FEB 11, 1993@09:55:38

  Effective Date: FEB 10, 1993           Type: COPAY INCOME EXEMPTION
          Status: EXEMPT               Reason: HARDSHIP
          Active: NO, INACTIVE           User: KAGAN,PETER
       How Added: MANUAL           When Added: FEB 11, 1993@09:56:22
Charges Canceled: FEB 10, 1993             To: FEB 11, 1993

  Effective Date: FEB 10, 1993           Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT           Reason: INCOME>PENSION
          Active: NO, INACTIVE           User: JOHN,STEPHEN
       How Added: SYSTEM           When Added: FEB 11, 1993@10:00:37

  Effective Date: FEB 10, 1993           Type: COPAY INCOME EXEMPTION
          Status: EXEMPT               Reason: HARDSHIP
          Active: NO, INACTIVE           User: KAGAN,PE TER
       How Added: MANUAL           When Added: FEB 11, 1993@10:00:49
Charges Canceled: FEB 10, 1993             To: FEB 11, 1993

  Effective Date: FEB 10, 1993           Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT           Reason: INCOME>PENSION
          Active: NO, INACTIVE           User: KAGAN,PETER
       How Added: SYSTEM           When Added: FEB 17, 1993@15:28:39
```

Medication Copayment Income Exemption Menu
Manually Change Copay Exemption (Hardships)

INTRODUCTION

This option is designed to grant and/or remove hardship waivers for patients who request the new copay income test. It may also be used to grant exemptions to Means Test patients; however, if MAS grants a hardship waiver to the Means Test by changing a patient's Means Test status from Category C to Category A, a hardship exemption is automatically generated.

A message or alert is generated anytime a hardship exemption is granted or removed. If the USE ALERTS site parameter is set to NO (or the field is left unanswered), a mail bulletin is generated; if set to YES, an alert is generated. A sample mail bulletin is provided in the example.

The system attempts to keep the effective date of the exemption the same as the effective date of the income test by defaulting to the effective date of the last exemption at the "Select Effective Date" prompt. Only the date of previous exemptions or the current date may be entered at this prompt.

Occasionally, the creation of a patient's exemption may be interrupted unexpectedly. In such cases, this option may be used to detect copay exemption discrepancies and correct/ update the patient's exemption status.

Once a waiver is granted, the exemption is good for one year from the date it is granted. An electronic signature code is required to grant a hardship waiver.

The chart on the following page shows the prompts and steps involved in using this option.

Medication Copayment Income Exemption Menu
Manually Change Copay Exemption (Hardships)

PROCESS

The following chart shows the steps and prompts involved in using the Manually Change Copay Exemption (Hardships) option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Medication Copayment Exemption Update Option		
	Select BILLING PATIENT:	.patient name	2
		.<??> for a list	1
		.up-arrow <^>	7
	This step will appear only if the patient selected has previously been granted a hardship exemption or the current patient exemption is incorrect.		
	The patient's copay exemption status data is displayed.		
2	Update Patient Billing Status? NO//	.<RET> to not change the status	8
		.YES to update the status and remove the hardship waiver	4
		.up-arrow <^>	7
	The patient's copay exemption status data is displayed.		
3	Do you wish to manually assign a Hardship Copay Exemption? NO//	.<RET> to not assign an exemption	8
		.YES if you wish to assign an exemption	4
		.up-arrow <^>	7

Medication Copayment Income Exemption Menu
Manually Change Copay Exemption (Hardships)

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Only the date of a previous exemption or the current date may be entered at this prompt. The default is the effective date of the last exemption.		
4	Select Effective Date: (10/30/92 - {current date}): {date}//	.<RET> to accept default	5
		.other date of a previous exemption between 10/30/92 (the conversion date) and the current date	5
		.up-arrow <^>	7
	If you are updating the patient billing status by removing the exemption, this prompt will not appear and you will proceed to Step 7.		
5	Are You Sure?	.YES to assign an exemption	6
		.NO to not assign the exemption	8
		.up-arrow <^>	7
6	Enter your Signature Code:	.electronic signature code	7
		.up-arrow <^>	7
	One or more messages regarding the current exemption status may appear before this prompt.		
7	Press RETURN to continue or '^' to exit:	.<RET>	1 or 8
		.up-arrow <^>	1

Medication Copayment Income Exemption Menu
Manually Change Copay Exemption (Hardships)

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	The copay exemption status data is redisplayed showing any newly entered information.		
8	Press RETURN to continue or '^' to exit:	.<RET> or up-arrow <^>	1
9	Return to the menu.		

Medication Copayment Income Exemption Menu
Manually Change Copay Exemption (Hardships)

EXAMPLE
The following example shows what might appear when using this option. User responses appear in boldface type, and the symbol <signature> is used to show an electronic signature code being entered. A sample mail bulletin is provided on the following page.

```
Medication Copayment Exemption Update Option


Select BILLING PATIENT:  JONES,SAMUEL   104010245 NON-EXEMPT NO INCOME DATA

Medication Copayment Income Exemption Status
JONES,SAMUEL   0245          Currently: NON-EXEMPT-NO INCOME DATA  01/22/93

EFFECTIVE   TYPE      STATUS      REASON                ADDED BY/ON
-------------------------------------------------------------------------------
01/22/93    RX COPAY  NON-EXEMPT  NO INCOME DATA        SYSTEM/ 03/09/93

Medication Copayment Exemption Status Currently computes to: NON-EXEMPT
There is insufficient income data on file for the prior year.


Do you wish to manually assign a Hardship Copay Exemption? NO//  Y  YES


Select Effective Date:  (10/30/92 - 3/10/93): JAN 22, 1993// <RET>
Are You Sure? Y  YES

Enter your Signature Code: <signature>   SIGNATURE VERIFIED
Deleting Active flag from current entry

Medication Copayment Exemption Status Updated: HARDSHIP   01/22/93

Press RETURN to continue or '^' to exit: <RET>



Medication Copayment Income Exemption Status
JONES,SAMUEL   0245          Currently: NON-EXEMPT-NO INCOME DATA  01/22/93

EFFECTIVE   TYPE      STATUS      REASON                ADDED BY/ON
-------------------------------------------------------------------------------
01/22/93    RX COPAY  EXEMPT      HARDSHIP              GRAY,MARK/ 03/10/93

Medication Copayment Exemption Status Currently computes to: NON-EXEMPT
There is insufficient income data on file for the prior year.


Press RETURN to continue or '^' to exit:
```

Medication Copayment Income Exemption Menu
Manually Change Copay Exemption (Hardships)

EXAMPLE, cont.

```
Subj: Medication Copayment Exemption Status Change  [#547] 20 Apr 93 14:53
  11 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1  **NEW**
---------------------------------------------------------------------------

The following Patient's Medication Copayment Exemption Status has changed:
    Patient: JONES,SAMUEL              PT. ID: 104-01-0245

 Old Status: NON-EXEMPT - NO INCOME DATA  Dated 03/09/93
 New Status: EXEMPT     - HARDSHIP  Dated 03/10/93



Patient has been given a Hardship Exemption.
    by: GRAY,MARK/(Manual)
    on: MAR 10, 1993 @ 14:53:40


Select MESSAGE Action: DELETE (from IN basket)//
```

Medication Copayment Income Exemption Menu
Letters to Exempt Patients

INTRODUCTION

This option is used to print the letters to be sent to patients who have been determined to be exempt from the medication copay. A range of patients and exemption effective dates may be specified. No letters will print for deceased patients, non-veterans, and patients who are SC>50%.

When this option is initially run, you are asked if you would like to store the results of the search in a template. If you answer YES, a search template, IB EXEMPTION LETTER, is created. This data may be accessed through the Print File Entries option in FileMan. For each subsequent search, you are asked if you wish to delete the results of the previous search. If you answer YES, the previous search template is deleted, and you again have the option of storing the results of your search. Only one IB EXEMPTION LETTER search template may exist at a time.

Medication copayment exemptions based on annual income must be re-evaluated yearly on the anniversary of a patient's means or copayment test. If a patient is exempt due to income below the threshold, a renewal date is shown below the "in reply" heading of the letter. The patient must complete a new copay income test by the renewal date or he/she will no longer be considered exempt from the pharmacy copayment requirement.

This letter is designed to be one page and to print to a pin fed printer, on plain paper, in either 10 or 12 pitch. The default is set to start the address on line 15; however, this may be edited through the Edit Copay Exemption Letter option. If address line three contains data, that data prints at the end of address line two. If defined, temporary addresses are used.

Due to the brevity of this option, no process chart is provided.

Medication Copayment Income Exemption Menu
Letters to Exempt Patients

EXAMPLE

The following example shows what might appear on your screen while using this option. User responses appear in boldface type. A sample letter is provided on the following page.

```
Print Exemption letters to patients


Delete Results of Previous Search? NO// YES

<<< Search Template IB EXEMPTION LETTER deleted!

Store results of Search in Template? YES// <RET>

<<< Search Template IB EXEMPTION LETTER created!

  START WITH COPAY EXEMPTION STATUS DATE: FIRST// <RET>
    START WITH PATIENT NAME: FIRST// <RET>
DEVICE: A138  A138-10/6/UP  DEVELOPMENT AREA    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)

WANT TO FREE UP THIS TERMINAL? NO// YES  (YES)
```

Medication Copayment Income Exemption Menu
Letters to Exempt Patients

EXAMPLE, cont.

Department of Veterans Affairs Medical Center
113 Holland Avenue
Albany, NY 12208

MAY 5, 1993

In Reply Refer To:
097-14-3307
Renewal Date: MAY 3, 1994

PETER KAGAN
77 MAIN ST
CABOT COVE, ME 09876

Public Law 102-568 enacted on October 29, 1992, provided for an exemption to the prescription copayment for those veterans who had income levels less than the maximum rate of VA pension. Charges established before October 29, 1992, were not exempted by the legislation.

We have reviewed your income and eligibility information contained in our records and determined that you are eligible for the exemption. We are currently reviewing your account and will make the appropriate adjustments to it in the near future. If you are eligible for a refund for payments made on charges established since October 29, 1992, we will forward you a check. While we are reviewing your account we will not be sending out a statement.

Medication copayment exemptions based upon annual income must be re-evaluated yearly on the anniversary of your means test or copayment test. If a renewal date is shown below the 'in reply' heading you must complete a new copay income test by that date or you will no longer be considered exempt from the pharmacy copayment requirement.

Please do not send in any more payments until we have completed this review and forwarded a statement to you.

FINANCE OFFICER

Medication Copayment Income Exemption Menu
List Income Thresholds

INTRODUCTION

This option allows you to print an output which lists the income thresholds used in the medication copayment income exemption process sorted by type of threshold and effective date.

If you accept the default of FIRST at the start date prompt, first to last is assumed.

This output requires 132 columns.

Due to the brevity of this option, no process chart is provided.

Medication Copayment Income Exemption Menu
List Income Thresholds

EXAMPLE

The following example shows what might occur on your screen while using this option followed by a sample output. User responses appear in boldface type.

```
                    Print Medication Copayment Income Thresholds


You will need a 132 column printer for this report!

  START WITH DATE: FIRST// <RET>
DEVICE: A137/10/6/UP  HP LASER     RIGHT MARGIN: 80// 132
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)

WANT TO FREE UP THIS TERMINAL? NO// <RET>  (NO)
```

```
Medication Copayment Income Thresholds                                    MAR 15,1993  08:29    PAGE 1
EFFECTIVE                    1          2          3          4          5          6          7          8   ADDITIONAL
DATE       BASE RATE  DEPENDENT  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS      AMOUNT
-------------------------------------------------------------------------------------------------------------------------------

       TYPE: PENSION PLUS A&A
DEC  1,1992   12187.00   14548.00   15844.00   17140.00   18436.00   19732.00   21028.00   22324.00   23620.00     1296.00
```

Medication Copayment Income Exemption Menu
Print Patient Exemptions or summary

INTRODUCTION

This option allows you to print a list of copayment exemption statistics. Both exempt and non-exempt patients are included.

You are given the option to print a detailed patient listing or a summary. The detailed report may be sorted by either exemption status or exemption reason. The information given includes the patient name, patient ID, primary eligibility code, status, reason for exemption/non-exemption, and status date. This data is followed by a summary showing subtotals for each exemption reason and totals for exempt and non-exempt patients. If you choose to "Print Summary Only", the detailed portion of the output is omitted. Deceased patients are not included in the summary provided with the detailed listing; however, if you choose to print the summary only, deceased patients are included.

When printing only a summary, sorting by the EXEMPTION STATUS default reduces the time required to produce the report.

The detailed patient listing requires 132 columns. You may wish to queue this output to print during non-work hours as it may be very lengthy.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Medication Copayment Income Exemption Menu
Print Patient Exemptions or summary

PROCESS
The following charts shows the steps and prompts involved in using the Print Patient Exemptions or summary option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	"Print Patient Medication Copayment Exemptions"		
	Print Summary Only? YES//	.<RET> to accept default	2
		.NO to include a detailed list of patients	2
		.up-arrow <^>	10
2	SORT BY: EXEMPTION STATUS//	.<RET> or .04 to sort by exemption status	3
		..05 to sort by exemption reason	3
3	START WITH COPAY INCOME EXEMPTION {REASON/STATUS}: FIRST//	.<RET> to accept default	5
		.first exemption reason/ status you wish to include	4
4	GO TO COPAY INCOME EXEMPTION {REASON/STATUS}: LAST//	.<RET> to accept default	5
		.last exemption reason/ status you wish to include	5
5	START WITH COPAY EXEMPTION STATUS DATE: FIRST//	.<RET> to accept default	7
		.T-365 to include only patients seen in the last year	6
6	GO TO COPAY EXEMPTION STATUS DATE: LAST//	.<RET> to accept default	7
		.last date you wish to include	7

Medication Copayment Income Exemption Menu
Print Patient Exemptions or summary

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
7	START WITH PATIENT NAME: FIRST//	.<RET> to accept default	9
		.first patient name you wish to include	8
8	GO TO PATIENT NAME: LAST//	.<RET> to accept default	9
		.last patient name you wish to include	9
9	You are prompted for a device at this step.		10
10	Return to the menu.		

Medication Copayment Income Exemption Menu
Print Patient Exemptions or summary

EXAMPLE

The following example shows what might appear on your screen while using this option. User responses appear in boldface type. A sample output is provided below.

```
                        Print Patient Medication Copayment Exemptions

Print Summary Only? YES// NO

You will need a 132 column printer for this report!

SORT BY: EXEMPTION STATUS// <RET>
START WITH COPAY INCOME EXEMPTION STATUS: FIRST// <RET>
  START WITH COPAY EXEMPTION STATUS DATE: FIRST// 1/1/93
  GO TO COPAY EXEMPTION STATUS DATE: LAST// 2/28/93
    START WITH PATIENT NAME: FIRST// <RET>
DEVICE: A137/16/6/UP  HP LASER     RIGHT MARGIN: 80// 132
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

REQUESTED TIME TO PRINT: NOW// t@1700  (MAR 15, 1993@17:00)
REQUEST QUEUED!



Patient Medication Copayment Exemption Report
                                                          MAR 15,1993  17:00    PAGE 1
PATIENT         PT ID        PRIMARY ELIGIBILITY  STATUS        REASON               STATUS DATE
-------------------------------------------------------------------------------------------------

TATE,MALCOLM    111-32-2233  NSC                  NON-EXEMPT    INCOME>PENSION       JAN 25,1993
THOMAS,JOHN     222-09-0999  SC                   NON-EXEMPT    INCOME>PENSION       FEB  1,1993
ZALINKA,SAMUEL  123-22-1223  NSC                  NON-EXEMPT    INCOME>PENSION       JAN 21,1993
SMITH,WILLIAM   123-28-1220  SC                   NON-EXEMPT    NO INCOME DATA       FEB  4,1993
STEVENS,JOHN    789-99-9876  SC                   NON-EXEMPT    NO INCOME DATA       FEB  4,1993
KELLY,JOHN      123-45-6789  NSC                  EXEMPT        DIS. RETIREMENT      FEB 10,1993
NOONAN,DAN      123-45-6789  NSC                  EXEMPT        DIS. RETIREMENT      FEB 17,1993
TAYLOR,ANDREW   012-04-1122  NSC                  EXEMPT        DIS. RETIREMENT      JAN 25,1993
JONES,RALPH     114-11-1144  NSC                  EXEMPT        HARDSHIP             FEB  5,1993
MCGUIRR,EAMON   097-01-1003  HUMANITARIAN         EXEMPT        NON-VETERAN          FEB 10,1993
KAGAN,PETER     012-54-4444  HUMANITARIAN         EXEMPT        NON-VETERAN          JAN 25,1993

================================================
Non-Exempt Status:
     INCOME>PENSION                    = 3
     NO INCOME DATA                    = 2
Exempt Status:
     DIS. RETIREMENT                   = 3
     HARDSHIP                          = 1
     IN RECEIPT OF A&A                 = 8
     IN RECEIPT OF HB                  = 0
     IN RECEIPT OF PENSION             = 0
     INCOME<PENSION                    = 0
     NON-VETERAN                       = 2

Total Exempt Patients                  = 5
Total Non-Exempt Patients              = 6
```

Medication Copayment Income Exemption Menu
Reprint Single Income Test Reminder Letter

INTRODUCTION

This option is used to generate an Income Test reminder letter for a patient whose effective copay exemption is based upon income.

If the patient is currently non-exempt due to no income data reported, a letter may be generated if the patient's previous exemption status is based on income.

Due to the brevity of this option, no process chart is provided.

Medication Copayment Income Exemption Menu
Reprint Single Income Test Reminder Letter

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses appear in boldface type. A sample letter is also provided.

```
Select BILLING PATIENT: KAGAN,PETER          03-02-45     342957333     NO
     NSC VETERAN

================================================================================
          Exemption Status: EXEMPT  (INCOME<PENSION)
            Exemption Date: 04/06/94

            Letter Printed: 12/14/96     Current Income Test Date: 04/06/94
================================================================================

Okay to print the reminder letter? Y  YES

*** Please note that the reminder letter prints in 80 columns. ***

DEVICE: HOME// A138 -10/6/UP  KYOCERA RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

Medication Copayment Income Exemption Menu
Reprint Single Income Test Reminder Letter

EXAMPLE, cont.

Department of Veterans Affairs Medical Center
113 Holland Avenue
Albany, New York 12208

DEC 14, 1995

In Reply Refer To:
342-95-7333

PETER KAGAN
54 BROADWAY
BOSTON, MA 04443

The VA is required by law to charge veterans who receive medications on an outpatient basis for the treatment of nonservice-connected conditions, a copayment of $2.00 for each 30-day (or less) supply of medication provided. Based on the income information requested each year, some veterans may be exempt from the copayment.

Our records indicate that your medication copayment exemption status will expire on December 31, 1995.

To update your income information so we may review your copayment exemption status, please call 462-3311 x9372 to set up an appointment to provide us with current income information.

Jane Reynolds

Chief, MAS

Medication Copayment Income Exemption Menu
Add Income Thresholds

INTRODUCTION

This option is used to enter/edit the income thresholds used in the medication copayment income exemption.

The thresholds are determined and released by VBA (Veterans Benefits Administration) December 1 of each year. These are the same thresholds used for A&A pensions.

Once the ADDITIONAL DEPENDENT AMOUNT is entered, the amount for each additional dependent can be automatically calculated when the copayment income exemptions are built. However, if the amount for each additional dependent does not have to be calculated, the exemption can be built much faster; therefore, it is advantageous to enter the amount for each dependent.

In the event that the new income thresholds are released or entered after the normal effective date, this package was designed to note exemptions created with thresholds over one year old and to allow automatic recomputation of just those exemptions. The process chart does not reflect this functionality; however, it works similarly to the Print/Verify Patient Exemption Status.

The chart on the following page shows the prompts and steps involved in using this option.

Medication Copayment Income Exemption Menu
Add Income Thresholds

PROCESS
The following chart shows the steps and prompts involved in using the Add Income Thresholds option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select BILLING THRESHOLDS DATE:	.date	2
		.<RET> or up-arrow <^>	9
2	ARE YOU ADDING {'date'} AS A NEW BILLING THRESHOLDS (THE nTH)?	.YES	3
		.NO	1
3	DATE: {date}//	.<RET> to accept default	4
		.other date	4
	The default of PENSION PLUS A&A is the only acceptable response.		
4	TYPE: PENSION PLUS A&A//	.<RET> to accept default	5
5	BASE RATE FOR VETERAN:	.enter the rate for a single veteran	6
		.<RET>	6
6	BASE RATE WITH 1 DEPENDENT:	.enter the amount for a veteran with one dependent	7
		.<RET>	7
7	ADDITIONAL DEPENDENT AMOUNT:	.enter the amount for each additional dependent	8
		.<RET>	8

Medication Copayment Income Exemption Menu
Add Income Thresholds

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	If the BASE RATE WITH {#} DEPENDENTS is equal to the BASE RATE FOR VETERAN plus the ADDITIONAL DEPENDENT AMOUNT, individual amounts do not have to be entered at the following prompts. The system can calculate each amount when building the exemption; however, the exemption will be built much faster if these entries are made.		
8	BASE RATE WITH {#} DEPENDENTS:	.enter the rate for the veteran plus the prompted number of dependents	SEE NOTE
	NOTE: You are prompted to enter an individual base rate for the veteran plus each of two through eight dependents. Any entry (including a <RET>) at any of these prompts brings you to the next appropriate prompt. After an entry is made for the eighth dependent, you will proceed to Step 9.		
9	Return to the menu.		

Medication Copayment Income Exemption Menu
Add Income Thresholds

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses appear in boldface type.

```
Select BILLING THRESHOLDS DATE: 12/1/93   DEC  1, 1993
  ARE YOU ADDING 'DEC  1, 1993' AS A NEW BILLING THRESHOLDS (THE 5TH)? Y  (YES)
DATE: DEC 1,1993// <RET>
TYPE: PENSION PLUS A&A// <RET>
BASE RATE FOR VETERAN: 12187
BASE RATE WITH 1 DEPENDENT: 14548
ADDITIONAL DEPENDENT AMOUNT: 1296
BASE RATE WITH 2 DEPENDENTS: 15844
BASE RATE WITH 3 DEPENDENTS: 17140
BASE RATE WITH 4 DEPENDENTS: 18436
BASE RATE WITH 5 DEPENDENTS: 19732
BASE RATE WITH 6 DEPENDENTS: 21028
BASE RATE WITH 7 DEPENDENTS: 22324
BASE RATE WITH 8 DEPENDENTS: 23620
```

Medication Copayment Income Exemption Menu
Print/Verify Patient Exemption Status

INTRODUCTION

This option will search the BILLING EXEMPTIONS file (#354.1) and compare the currently stored active exemption for each patient against what the system calculates to be the correct exemption status for the patient based on current data from the MAS files.

Once you select a date range, you are asked whether or not you wish to update each incorrect exemption status. If you enter NO, a list of discrepancies is printed without updating the incorrect statuses. If you enter YES, the same report will print and the statuses are updated. Initially, the report should be run without updating the exemptions.

The Manually Change Copay Exemptions (Hardship) option may also be used to update exemptions to the correct status one patient at a time.

This output requires 132 columns. You may wish to queue to print during non-work hours as it can be quite lengthy.

Due to the brevity of this option, no process chart is provided.

Medication Copayment Income Exemption Menu
Print/Verify Patient Exemption Status

EXAMPLE

The following example shows what might appear on your screen while using this option followed by a sample of the output generated if you choose to update the incorrect exemptions. User responses appear in boldface type.

```
Verify Medication Copayment Exemption Status


Start with DATE: 1/1  (JAN 01, 1993)
Go to DATE: t  (MAR 17, 1993)

Update Patient Status? NO// <RET>


You will need a 132 column printer for this report!

DEVICE: HOME// B200  LASER PRINTER    RIGHT MARGIN: 80// 132

HMMMM, LET ME THINK ABOUT THIS FOR A MINUTE



Medication Copayment Exemption Problem Report                                    MAR 17, 1993 09:42 Page 1
Patient     PT. ID       Error               Current Exemption        Computed Exemption       Action
-------------------------------------------------------------------- ------------------------------------------------------------
KELLY,JOHN  123-45-6789  Exemption incorrect  02/10/93 NO INCOME DATA  02/10/93 INCOME<PENSION  Nothing Updated
NOONAN,DAN  123-45-6789  Exemption incorrect  02/17/93 NO INCOME DATA  02/17/93 INCOME<PENSI ON  Nothing Updated
TAYLOR,JON  012-04-1122  Exemption incorrect  01/25/93 DIS. RETIREMENT 01/25/93 INCOME<PENSION  Nothing Updated




There were 3 discrepancies found in 75 exemptions checked.
```

MCCR System Definition Menu
Activate Revenue Codes

INTRODUCTION

The Activate Revenue Codes option allows users to activate the revenue codes which their sites have chosen to use for third party billing.

The revenue codes are provided by the National Uniform Billing Committee. The full set of 999 codes is sent to each site. All codes have an INACTIVE status when received. The site chooses which codes they wish to use for billing purposes by activating them through this option. Some of the codes are reserved for national assignment (no definition as yet). These reserve codes cannot be activated. Only activated revenue codes may be selected during the billing process.

Adding codes to or deleting them from the REVENUE CODE file is NOT allowed.

Only holders of the IB SUPERVISOR security key may access this option.

You may enter a question mark <?> at the "Select REVENUE CODE" prompt for a list of the codes. At the "ACTIVATE" prompt, you may enter a 1 or A for activate, 0 or I for inactivate.

Due to the brevity of this option, a process chart has not been provided.

MCCR System Definition Menu
Activate Revenue Codes

EXAMPLE
The following are examples of what might appear on the screen while using the Activate Revenue Codes option. User responses are shown in boldface type.

EXAMPLE 1 - Activating Code

```
Select REVENUE CODE:  100   100   ALL INCL R&B/ANC   ALL-INCLUSIVE
ROOM AND BOARD PLUS ANCILLARY
ACTIVATE:  ACTIVATE CODE
```

EXAMPLE 2 - Inactivating Code

```
Select REVENUE CODE:  136   136   DETOX   DETOXIFICATION
ACTIVATE: ACTIVATE CODE//  INACTIVATE CODE
```

MCCR System Definition Menu
Enter/Edit Automated Billing Parameters

INTRODUCTION The Enter/Edit Automated Billing Parameters option is used to enter or edit the parameters that control automated third party billing. Only entries in the Claims Tracking module will be billed automatically. Currently, only inpatient stays, outpatient encounters, and prescription refills are included in automated billing.

Following is a brief description of the parameters.

AUTO BILLER FREQUENCY
Number of days between each execution of the automated biller. For example, if the auto biller should run once a week, enter 7; if it should run every night, enter 1. If this field is left blank, the auto biller will never run.

INPATIENT STATUS (AB)
This is the status that a PTF record must be in before the automated biller will attempt to create an inpatient bill. The PTF record must be closed before an automated bill can be created.

AUTOMATE BILLING
This parameter controls the automated creation of bills. If this field is set to YES, the bills will be automatically created for possible billable events with no user interaction. If this field is left blank, the EARLIEST AUTO BILL DATE must be added to each event in Claims Tracking before a bill is automatically created by the auto biller.

BILLING CYCLE
This is the maximum number of days allowed to be billed on a single bill. If this field is left blank, the date range will default to the event date through the end of the month in which the event took place or for inpatient interim bills, the next month after the last interim bill.

Claims Tracking events may be added to the list of events for which an auto bill should be created by adding a date to the EARLIEST AUTO BILL DATE in Claims Tracking. Events may be removed from the auto biller list by adding a REASON NOT BILLABLE or deleting the EARLIEST AUTO BILL DATE.

MCCR System Definition Menu
Enter/Edit Automated Billing Parameters

INTRODUCTION cont.

DAYS DELAY

This field controls the number of days after the end of the BILLING CYCLE that a bill should be created. This parameter is used at two different points to determine if a bill should be created. The first is when the Claims Tracking entry is first created. At that time, the EARLIEST AUTO BILL DATE will be set to the current date plus the number of DAYS DELAY. The second time this parameter is used is when the auto biller is trying to set up a date range for the events bill. In that case, DAYS DELAY is added to the BILLING CYCLE to determine if the correct amount of time has elapsed for the bill to be created.

For example, if DAYS DELAY is 3 and BILLING CYCLE is 10, a bill will not be created for at least 13 days after the initial entry was created in Claims Tracking. Inpatients are slightly different. If an inpatient is discharged, the auto biller will try to create a bill for that stay DAYS DELAY after the discharge date. The auto biller cannot, however, create a bill until the PTF record is closed. Therefore, the actual delay before bill creation for inpatient bills may be longer than DAYS DELAY.

The MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

The chart on the following page shows the prompts and steps involved in using this option.

MCCR System Definition Menu
Enter/Edit Automated Billing Parameters

PROCESS

The following chart shows the prompts and steps involved in using the Enter/Edit Automated Billing Parameters option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	AUTO BILLER FREQUENCY:	.number of days between executions of automated biller	2
		.<RET> (no default)	7
	This is the status that a PTF record must be in before the automated biller will attempt to create an inpatient bill. The automated biller cannot create an inpatient bill before the PTF record is closed.		
2	INPATIENT STATUS (AB):	.1 Closed	3
		.2 Released	3
		.3 Transmitted	3
	Even though PROSTHETIC ITEM AND SCHEDULED ADMISSION appear as choices at this prompt when <??> are entered, the current automated billing functionality only includes inpatient stays, outpatient encounters, and prescription refills.		
3	Select CLAIMS TRACKING TYPE NAME:	.INPATIENT ADMISSION	4
		.OUTPATIENT VISIT	4
		.PRESCRIPTION REFILL	4
		.<RET>	7
	The following prompts may appear with defaults if data has been previously entered. Enter a <RET> to accept the default value.		
4	AUTOMATE BILLING:	.1 or YES if automated creation of bills should take place with no user intervention in Claims Tracking	5
		.<RET> (no default) for NO	3
5	BILLING CYCLE:	.maximum number of days allowed to be billed on a single bill	6
		.<RET> (no default) for one month range	6

MCCR System Definition Menu
Enter/Edit Automated Billing Parameters

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
6	DAYS DELAY:	.number of days after the end of the billing cycle bills should be created	3
		.<RET>	3
7	Return to the menu.		

MCCR System Definition Menu
Enter/Edit Automated Billing Parameters

EXAMPLE
The following is an example of what may appear on your screen while using the Enter/Edit Automated Billing Parameters option. User responses appear in boldface type.

```
AUTO BILLER FREQUENCY: 1
INPATIENT STATUS (AB): CLOSED

Select CLAIMS TRACKING TYPE NAME: INPATIENT ADMISSION
AUTOMATE BILLING: YES
BILLING CYCLE: 30
DAYS DELAY: 2

Select CLAIMS TRACKING TYPE NAME: OUTPATIENT VISIT
AUTOMATE BILLING: YES
BILLING CYCLE: 30
DAYS DELAY: 10

Select CLAIMS TRACKING TYPE NAME: PRESCRIPTION REFILL
AUTOMATE BILLING: YES
BILLING CYCLE: 60
DAYS DELAY: 10

Select CLAIMS TRACKING TYPE NAME:
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Print Check-off Sheet for Appointments

INTRODUCTION

The Print Check-off Sheet for Appointments option allows you to print Ambulatory Surgery Check-Off Sheets by patient name or clinic for a specified appointment date. The intent of the check-off sheet is to assist in the billing for BASC procedures. The applicable CPT code(s) for ambulatory surgical procedures may be checked off by the physician and forwarded to billing for processing.

The check-off sheet produced by this option provides some additional patient information that the generic check-off sheet produced by the Check-off Sheet Print option doesn't include. Means Test eligibility, service-connected disabilities, and all active insurance carriers are provided.

Appointments must be in clinics that have been assigned to a check-off sheet through the Build CPT Check-off Sheet option. Appointment check-off sheets cannot be printed for appointments that are NO SHOW or CANCELLED.

If you select the appointment date by clinic, the check-off sheets may be sorted by clinic or terminal digit, and one, many or all divisions and clinics may be included. If you select by patient name, all clinic appointments for that patient for the specified appointment date will be displayed for selection.

This output requires 132 column margin width.

The chart beginning on the following page shows the prompts and steps involved in using this option.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Print Check-off Sheet for Appointments

PROCESS

The following chart shows the prompts and steps involved in using the Print Check-off Sheet for Appointments option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Print Appointment Check-Off Sheets Select one of the following: P Patient Name C Clinic Select Appointment by: Clinic//	.<RET> or C to select the appointment by clinic .P to select by patient .up-arrow <^>	2 3 10
2	Sort sheets by: (C/T): Clinic//	.<RET> or C to sort check-off sheets by clinic and patient name .T to sort by terminal digit	3 3
3	Appointment DATE: {date}//	.<RET> to accept default .other date	4 4
	After the following message is displayed, you will proceed to Step 5 if you chose to select the appointment by clinic and Step 7 if you chose to select the appointment by patient name.		
4	"Only Clinics and Patients with Appointments on this Date will be allowed. Appointments must be in Clinics that have a Check-Off Sheet to be chosen."		5 or 7
	If a division is entered at this step, you will be prompted to select another division until a <RET> is entered.		
5	Select division: ALL//	.<RET> to accept default .a specific division	6 5

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Print Check-off Sheet for Appointments

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	If a clinic name is entered at this step, you will be prompted to select another clinic until a <RET> is entered.		
6	Select clinic: ALL//	.<RET> to accept default	9
		.a specific clinic	6
7	Select PATIENT NAME:	.patient name	8
		.<RET>	9
	An appointment profile for the selected patient will be displayed providing the clinic, appointment date/time, and appointment type.		
8	Select Appointments: (#-#):	.corresponding number of the appt. you wish to include	7
		.<RET> or up-arrow <^>	7
9	You will be prompted for a device at this step. This report requires a 132 column margin width.		10
10	Return to the menu.		

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Print Check-off Sheet for Appointments

EXAMPLE
The following is an example of what may appear on your screen while using the Print Check-off Sheet for Appointments option. User responses are shown in boldface type. A sample of one of the check-off sheets that may be printed is provided on the following page.

```
                    Print Appointment Check-Off Sheets


     Select one of the following:

          P         Patient Name
          C         Clinic

Select Appointment by: Clinic// <RET>
Sort sheets by:  (C/T): Clinic// Terminal Digits
Appointment DATE: APR 2,1992// <RET> (APR 02, 1992)

Only Clinics and Patients with Appointments on this Date will be allowed.
Appointments must be in Clinics that have a Check-Off Sheet to be chosen.


Select division: ALL// <RET>
Select clinic: ALL// DERMATOLOGY
Select another clinic: <RET>
This report requires a 132 column printer for the CPT list to print.
OUTPUT DEVICE: HOME// A137      HALLWAY LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Print Check-off Sheet for Appointments

EXAMPLE, cont.

AMBULATORY SURGERY CHECK-OFF SHEET I NS

Patient Name: KAGAN,PETER
Patient Id: 258-74-1236
Clinic: DERMATOLOGY
Appointment Date/Time: APR 2,1992@09:00
Appointment Type: REGULAR

Means Test: MEANS TEST NOT REQUIRED
Last Means Test: AUG 25,1988
Primary Eligibility: SERVICE CONNECTED 50% to 100%
Service Connected: 50%

Insurance: AETNA
SC Disabilities: 1 KNEE PROSTHESIS 40%
2 MIGRAINE HEADACHES 10%

EKG ( ) LAB ( ) X-RAY ( )

Visit for SC condition: 1, 2
Diagnosis: Signature:

CPT Codes for DERMATOLOGY

REMOVAL OF SKIN LESION, TRUNK, ARMS, OR LEGS

11400	benign 0.5cm or less		( )
11600	malig. 0.5cm or less		( )
11401	benign .06 to 1.0cm		( )
11601	malig. 0.6 to 1.0cm		( )
11402	benign 1.1 to 2.0cm		( )
11602	malig. 1.1 to 2.0cm		( )
11606	benign over 4.0cm		( )
11643	malig. 2.1 to 4.0cm		( )
11644	malig 3.1 to 4.0cm		( )

REMOVAL OF SKIN LESION, SCALP, NECK, HANDS

11420	benign 0.5cm or less		( )
11620	malig. .05cm or less		( )
11421	benign .06 to 1.0cm		( )
11621	malig. 0.6 to 1.0 cm		( )
11422	benign 1.1 to 20.cm		( )
11622	malig. 1.1 to 2.0cm		( )
11426	benign over 4.0cm	306.24	( )

REMOVAL OF SKIN LESION, FACE, EARS, EYELIDS

11440	benign 0.5cm or less		( )
11640	malig. 0.5cm or less		( )
11441	benign .06 to 1.0cm		( )
11641	malig 0.6 to 1.0cm		( )
11442	benign 1.1 to 2cm		( )
11642	malig 1.1 to 2cm		( )
11446	benign over 4.0cm	306.24	( )
11646	malig over 4.0cm		( )

MISCELLANEOUS

40654	repair lip	306.24	( )
11000	biopsy of lesion	666.40	( )
11101	biopsy of additional lesion		( )
11200	removal of skin (15)		( )
11201	removal of skin (over 15)		( )
11730	removal of plate	228.80	( )
12011	repair superficial wound		( )
17000	destruction of face lesion		( )
17001	destruction of face lesions 2&3		( )
17002	destruction of face lesions, over 3		( )

REMOVAL OF TUMOR

21555	neck/chest		( )
23075	shoulder		( )
24075	upper arm/elbow		( )
25075	forearm/wrist		( )
26115	hand/finger		( )
27618	lower leg		( )
28043	foot		( )

DRAIN

10003	sebaceous cyst		( )
10101	infected nail (s)		( )
10141	hematoma	306.24	( )

CLEANSING

11000	surgical of skin	666.40	( )
11001	each add 10%		( )
11042	debr idement skin subq	306.24	( )

TRIM

11050	skin lesion (1)		( )
11051	skin lesion (2-4)		( )
11052	skin lesion (over 4)		( )

REMOVAL

11731	second nail plate	306.24	( )
11750	nail bed	352.00	( )
11752	nail bed/fingertip		( )

CLOSURE

12020	split wound (simple)	666.40	( )
12021	split wound (packing)	685.52	( )

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Purge Update File

INTRODUCTION

The Purge Update File option is used to delete all CPT entries in the temporary file, UPDATE BILLABLE AMBULATORY SURGICAL CODE (#350.41) that have been successfully transferred to the permanent file, BILLABLE AMBULATORY SURGICAL CODE (#350.4). Upon completion a total number of entries deleted is provided.

If the UPDATE BILLABLE AMBULATORY SURGICAL CODE file is not purged, the next time you transfer the file through the Run Amb. Surg. Update option, all of the entries that were previously transferred successfully will show as errors under "Codes already have entries for given effective date" and "Codes unable to transfer".

Only holders of the XUMGR security key may access this option.

Due to the brevity of this option, no process chart is provided.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Purge Update File

EXAMPLE
The following is an example of what may appear on your screen while using the Purge Update File option. User responses are shown in boldface type.

```
            Delete Transfered Codes from the Temporary BASC File


This option will only delete BASC codes in the temporary file that have
already been transferred to the permanent BASC file.
Do you want to delete transferred codes now? Y  YES

Processing, this could take some time.   Please wait...


Done.  1443 entries deleted from 350.41.
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Locality Modifier Enter/Edit

INTRODUCTION

The Locality Modifier Enter/Edit option allows you to enter or edit division information for a specific effective date which directly affects CPT billing rates. These entries must be made or no billing will occur.

The rates for ambulatory surgery procedures are based on a complex algorithm involving variables which are entered and edited through this option. To compute a specific bill, the base CPT amount is divided into wage and non-wage components. To account for geographic wage differences, the wage component of the base rate is adjusted by a locality modifier. Wage and non-wage components and the locality modifier are entered and edited through this option. These components are established and updated (usually yearly) by HCFA (Health Care Finance Administration).

The amount of the non-wage percentage is automatically calculated from the amount you enter for the wage percentage. The total of both components will equal 100%.

The chart beginning on the following page shows the prompts and steps involved in using the Locality Modifier Enter/Edit option.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Locality Modifier Enter/Edit

PROCESS

The following chart shows the prompts and steps involved in using the Locality Modifier Enter/Edit option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select MEDICAL CENTER DIVISION:	.division for which you wish to enter/edit an effective date	2
		.<RET> or up-arrow <^>	8
2	A billing profile is displayed for the medical center division selected at Step 1 providing the status, wage percentage, non-wage percentage, and locality modifier for each existing effective date. If you arrive at this step after editing, the new values are displayed. At the first occurrence of this step, you will proceed to Step 3. For subsequent occurrences, you will return to Step 1.		1 or 3
	If you enter a new effective date at this prompt, an additional prompt "Are you adding a new WAGE PERCENTAGE entry to this DIVISION?" will also appear.		
3	Select PROCEDURE EFFECTIVE DATE:	.effective date you wish to edit	4
		.a new effective date	4
		.<RET> (first occurrence of this prompt)	1
		.<RET> (subsequent occurrences of this prompt)	2
	Entry of a different date at this prompt will not create a new effective date. It will change the effective date you selected at Step 3.		
4	EFFECTIVE DATE: {date}//	.<RET> to accept default	5
		.other date	5
		.<@> to delete entire entry	3

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Locality Modifier Enter/Edit

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Defaults will appear for Steps 5 through 7 only if you are editing an existing effective date. The entry at this prompt is the status for the division on or after the selected effective date.		
* 5	STATUS: {status}//	.<RET> to accept default (ACTIVE)	6
		.<RET> to accept default (INACTIVE)	3
		.1 or ACTIVE	6
		.0 or INACTIVE	3
	The non-wage percentage is automatically calculated from your entry at this prompt. The total value of the wage percentage and non-wage percentage will equal 100%.		
* 6	WAGE PERCENTAGE: .{#}//	.<RET> to accept default	7
		.other percentage	7
* 7	LOCALITY RATE MODIFIER: {#}//	.<RET> to accept default	3
		.other percentage	3
8	Return to the menu.		

*Required field.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Locality Modifier Enter/Edit

EXAMPLE
The following is an example of what may appear on your screen while using the Locality Modifier Enter/Edit option for a new entry. User responses are shown in boldface type.

```
Select MEDICAL CENTER DIVISION:   TROY        500T

                    Medical Center Division Billing Profile

TROY

                              Wage            Non-Wage
  Effective Date   Status    Percentage      Percentage     Locality Modifier
  --------------   ------    ----------      ----------     -----------------

------------------------------------------------------------------------------
Select PROCEDURE EFFECTIVE DATE: 1/1  (JAN 01, 1992)
Are you adding a new WAGE PERCENTAGE entry to this DIVISION?  Y  YES
EFFECTIVE DATE: JAN 01, 1992// <RET>
STATUS: 1 ACTIVE
WAGE PERCENTAGE: .3445
LOCALITY RATE MODIFIER: .8890

Select PROCEDURE EFFECTIVE DATE: <RET>



                    Medical Center Division Billing Profile

TROY

                              Wage            Non-Wage
  Effective Date   Status    Percentage      Percentage     Locality Modifier
  --------------   ------    ----------      ----------     -----------------
   JAN  1,1992     ACTIVE      0.3445          0.6555            .8890

------------------------------------------------------------------------------


Select MEDICAL CENTER DIVISION:
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
List Transfer Errors

INTRODUCTION

The List Transfer Errors option produces a listing of all entries in the temporary UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) that have not yet transferred to the permanent BILLABLE AMBULATORY SURGICAL CODE file (#350.4). This includes those procedures that could not transfer due to error, as well as those that have not yet attempted to transfer.

The report lists the procedure (CPT code), effective date, the old and new rate groups (if applicable), update action (CREATED, CHANGED GROUPS, ACTIVATED, or DEACTIVATED), and the error message. This information is listed in numerical order by CPT code.

Following are the errors that may be displayed, a description, and/or the action that should be taken.

STATED OLD GROUP DOES NOT MATCH CURRENT GROUP - Old group, as reported by the HCFA update, doesn't match what's being used in Billing.

Action

- Notify billing of the difference.
- Delete old rate group from the UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) for the CPT effective date.
- Rerun the transfer through the Run Amb. Surg. Update option.

NO VALID UPDATE ACTION FOUND, NO CHANGE IN RATE/STATUS - The new entry would not change the CPT's status or rate group. Transfer was not necessary. No action needed.

DEACTIVATING A CODE ALREADY INACTIVE - The transfer was deactivating a CPT that is not active. Transfer was not necessary. No action needed.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
List Transfer Errors

INTRODUCTION cont.

DEACTIVATING A CODE NOT IN BILLING - The transfer was deactivating a CPT that was never used in billing. Transfer was not necessary. No action needed.

DATE EFFECTIVE ALREADY DEFINED FOR THIS CODE - There is already an entry for the CPT for the effective date.

Action

- If the entry in the UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) is different from the entry in the BILLABLE AMBULATORY SURGICAL CODE file (#350.4), determine which is correct.
- Correct the entry, if necessary, in file #350.4. No action is necessary to file #350.41.

CODE NOT ACTIVE IN CPT FILE (#81) - The code is inactive in the CPT file.

Action

- Determine that you have the current CPT file.
- Determine that the status in the CPT file is the correct status.
- If the code is inactive, no action is necessary. If the CPT file is incorrect, contact your site manager about correcting the status in the CPT file.
- Rerun the transfer through the Run Amb. Surg. Update option.

ERROR WHILE TRYING TO STORE THE DATA - This is a technical error.

Action

- Contact your site manager.

If a CPT code is listed with no update action and no error message, there has not yet been an attempt to transfer that code through the Run Amb. Surg. Update option.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
List Transfer Errors

INTRODUCTION cont.

You will be prompted for a range of CPT codes and effective date(s).

Due to the brevity of this option, no process chart is provided.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
List Transfer Errors

EXAMPLE
The following is an example of what might appear on your screen while using the List Transfer Errors option followed by a sample output. User responses are shown in boldface type.

```
 START WITH PROCEDURE: FIRST// <RET>
    START WITH DATE EFFECTIVE: FIRST// 1/1/92
    GO TO DATE EFFECTIVE: LAST// 1/1/92
DEVICE: A137  LASER  RIGHT MARGIN: 132// <RET>
```

```
UPDATE BILLABLE AMB. SURG. ERROR LIST                          MAR 11,1992  09:00    PAGE 1
           DATE
PROCEDURE  EFFECTIVE    OLD GROUP  NEW GROUP  UPDATE ACTION  ERROR
---------------------------------------------------------------------------------------- ---

65230      JAN  1,1992  RATE 1                CREATED        DEACTIVATING A CODE NOT IN BILLING
66701      JAN  1,1992  RATE 1                ACTIVATED      DEACTIVATING A CODE ALREADY INACTIVE
66721      JAN  1,1992  RATE 3     RATE 2                     CODE NOT ACTIVE IN CPT
66800      JAN  1,1992  RATE 1     RATE 1                    CODE NOT ACTIVE IN CPT
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Delete/List Inactive Codes on Check-off Sheets

INTRODUCTION

This option allows you to list and delete CPT codes from check-off sheets that are AMA (American Medical Association) inactive or inactivated nationally, locally, or in billing. This should be done after CPT codes are updated (usually annually).

The "list" function of this option compares all check-off sheets with codes inactivated, and provides you with a list of inactive codes that are appearing on your check-off sheets. You may then choose to delete either codes inactivated by the AMA; codes inactivated nationally, locally, or in billing; or both. These codes may also be deleted manually through the Build CPT Check-off Sheet option.

Due to the brevity of this option, no process chart is provided.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Delete/List Inactive Codes on Check-off Sheets

EXAMPLE
The following example shows what may appear on your screen while using this option. User responses are shown in boldface type.

```
     Select one of the following:

          1         LIST INACTIVE CODES ON  CHECK-OFF SHEETS
          2         DELETE INACTIVE CODES FROM CHECK-OFF SHEET

Enter response: 1  LIST INACTIVE CODES ON CHECK-OFF SHEETS
OUTPUT DEVICE: HOME// <RET>  Decnet    RIGHT MARGIN: 80// <RET>



INACTIVE CPT CODES ON CHECK-OFF SHEETS            JUN 04, 1992  13:33   PAGE 1

PROCEDURE                     CHECK-OFF SHEET           SUBHEADER
------------------------------------------------------------------------------

               AMA INACTIVE

10003  DRAIN & TREAT SKIN L  DERMATOLOGY               DRAIN
10101  DRAINAGE OF INFECTED  DERMATOLOGY              DRAIN
                             ORTHOPEDICS               NAIL
30111  REMOVAL OF NOSE POLY  DERMATOLOGY              CLEANSING
30902  CONTROL OF NOSEBLEED  DERMATOLOGY              MIS CELLANEOUS

               NATIONALLY, LOCALLY AND BILLING INACTIVE

42100  BIOPSY ROOF OF MOUTH  GEN MED                  MOUTH
                             SURGICAL                  DERMATOLOGY

Press RETURN to continue or '^' to exit: <RET>

     Select one of the following:

          1         LIST INACTIVE CODES ON CHECK-OFF SHEETS
          2         DELETE INACTIVE CODES FROM CHECK-OFF SHEET

Enter response: 2  DELETE INACTIVE CODES FROM CHECK-OFF SHEET
DELETE AMA INACTIVE CODES? No// YES
DELETE OTHER INACTIVE CODES? No// YES
Deleting
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

INTRODUCTION The Build CPT Check-off Sheet option allows you to build a new CPT check-off sheet or edit an existing one.

This option allows you a great deal of flexibility in formatting the check-off sheet. You determine the number of columns, the position of data elements within a column, whether the associated charges will be displayed, in what order subheaders will be displayed within check-off sheets, and in what order procedures will be displayed within subheaders.

The subheader and procedure names are free text; however, the procedures must be selected by the CPT code. The name can then be edited to any free text entry you desire. A procedure must be either nationally, locally, or billing active to be selected. The number of columns on a page determines the column width and the number of characters allowed for subheader and procedure names. Naturally, two columns will allow more text than three. If the charge is displayed, the number of characters available for a subheader/procedure name is decreased by 10.

If you change the number of columns from two to three or change from NO to YES at the "DISPLAY CHARGE" prompt, a portion of your descriptions may be dropped.

You may select one of two syntax for position of data elements within a column, CODE/NAME/$ or NAME/CODE/$.

The print order is accomplished by numbering each entry at the "PRINT ORDER" prompt with a number between 1 and 9999. It is recommended that you not number in a 1, 2, 3 sequence; instead, 3, 6, 9 is a better format as it leaves room for changes and new entries. Leave as much space between numbers as you think you may need for changes in the print order or adding new subheaders and procedures; otherwise, you will have to renumber all entries when a change is made.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

INTRODUCTION cont.

A specific clinic may also be assigned to a check-off sheet. This is used when ambulatory surgery check-off sheets are printed for a given date, for individual appointments, or for each appointment in a particular clinic(s) through the Print Check-off Sheet for Appointments option. Appointments and clinics chosen through that option must have been assigned to a check-off sheet through this option.

If you delete a check-off sheet or subheader, everything within that sheet or header is deleted. If you want to retain the entries under a new name, edit the name rather than deleting.

The Most Commonly used Outpatient CPT Codes option is used to list the most common ambulatory procedures and ambulatory surgeries performed in a date range for a given set of clinics. This may be used to help select procedures to be used when building the CPT check-off sheets.

The output requires 132 column margin width.

The chart beginning on the following page shows the prompts and steps involved in using this option.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

PROCESS

The following chart shows the prompts and steps involved in using the Build CPT Check-off Sheet option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Build Check-Off Sheets		
	Select Check-Off Sheet:	.an existing entry	2
		.new entry	3
		.<RET> or up-arrow <^>	15
2	Edit this CHECK-OFF SHEET? NO//	.<RET>	10
		.YES	3
		.up-arrow <^>	1
	If you are entering or editing a check-off sheet name, you will proceed to Step 5. If you are entering or editing a subheader or procedure name, you will proceed to Step 4.		
3	NAME: {check-off sheet/ subheader/procedure name}//	.<RET> to accept default	4 or 5
		.other name	4 or 5
		.up-arrow <^>	3
		.<@> to delete the entry	1
	Defaults will appear at Steps 4 through 7 if you are editing an existing entry.		
	Your response at this prompt determines the print order for subheaders within check-off sheets and procedures within subheaders.		
*4	PRINT ORDER:	.a number between 1 and 9999	12

*Required field

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
*5	DISPLAY CHARGE:	.YES for CPT charge to print on check-off sheet	6
		.NO	6
*6	COLUMNS:	.2 for two vertical columns	7
		.3 to display three	7
*7	LINE FORMAT:	.1 for CODE/NAME/$	8
		.2 for NAME/CODE/$	8
8	Select CLINIC:	.clinic you wish to assign to this check-off sheet	9
		.<RET>	10
		.up-arrow <^>	10
	This is the check-off sheet to be associated with the clinic chosen. If the clinic is not yet assigned a check-off sheet, the default will be the check-off sheet being edited; otherwise, the default will be the name of the check-off sheet currently assigned to the clinic.		
9	PROCEDURE CHECK-OFF SHEET: {name}//	.<RET> to accept default	8
		.other check-off sheet	8
		.up-arrow <^>	8
	An Ambulatory Surgery Check-Off Sheet Profile is displayed providing the check-off sheet name, whether or not the charge will be displayed, number of columns, line format, associated clinics, subheader(s), and print order for each subheader.		
10	Select SUBHEADER:	.new subheader for this check-off sheet	3
		.existing subheader	11
		.<RET> or up-arrow <^>	13

*Required field

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
11	Edit SUBHEADER? NO//	.<RET> or NO	12
		.YES	3
		.up-arrow <^>	10
	<?> or <??> entered at this prompt will display the CPT list followed by a redisplay of the Ambulatory Surgery Subheader Profile. This may be used to check the print order after several procedures have been entered. An Ambulatory Surgery Subheader Profile is displayed providing the subheader name(s), associated check-off sheet, print order for subheader(s), procedure(s), print order for each procedure(s), and charge amount associated with each procedure based on the primary division.		
12	Select a PROCEDURE:	.number of new or existing procedure	3
		.<RET> or up-arrow <^>	10
13	Print this SHEET? NO//	.<RET> or NO	1
		.YES	14
		.up-arrow <^>	1
14	You will be prompted for a device at this step. This output requires a 132 column margin width.		1
15	Return to the menu.		

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

EXAMPLE

Following is an example of what may appear on your screen while using the Build CPT Check-off Sheet option. This is an abbreviated example of what would be entered to produce the sample output that follows. User responses are shown in boldface type.

```
                                   Build Check-Off Sheets

Select Check-Off Sheet: DERMATOLOGY
   ARE YOU ADDING 'DERMATOLOGY' AS A NEW AMBULATORY CHECK-OFF SHEET (THE 11TH)?  Y (YES)
NAME: DERMATOLOGY// <RET>
DISPLAY CHARGE: YES
COLUMNS: 2  TWO VERTICAL
LINE FORMAT: 1  CODE/NAME/$
Select CLINIC: DERMATOLOGY
PROCEDURE CHECK-OFF SHEET: DERMATOLOGY// <RET>
Select CLINIC: <RET>


                          Ambulatory Surgery Check-Off Sheet Profile

DERMATOLOGY

    CHARGE
    DISPLAYED  # OF COLUMNS     LINE FORMAT   ASSOCIATED CLINICS
    ---------  ------------     -----------   ------------------
       YES     TWO VERTICAL     CODE/NAME/$   DERMATOLOGY

    SUBHEADER                                                    PRINT ORDER
    ---------                                                    -----------

------------------------------------------------------------------------------
Select SUBHEADER: REMOVAL OF SKIN LESION, TRUNK, ARMS OR LEGS
   ARE YOU ADDING 'REMOVAL OF SKIN LESION, TRUNK ARMS OR LEGS' AS A NEW AMBULATORY SURG. CHECK -
OFF SHEET PRINT FIELDS? Y  (YES)
NAME: REMOVAL OF SKIN LESION, TRUNK ARMS OR LEGS  Replace <RET>
PRINT ORDER: 3


                              Ambulatory Surgery Subheader Profile

REMOVAL OF SKIN LESION, TRUNK ARMS OR LEGS

 CHECK-OFF SHEET                                          PRINT ORDER
 ---------------                                          -----------
 DERMATOLOGY                                                    3

 PROCEDURES                                               PRINT ORDER  CHARGE
 ----------                                               -----------  ------

------------------------------------------------------------------------------
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

EXAMPLE, cont.

```
        Select a PROCEDURE: 11400          REMOVAL OF SKIN LESION
NAME: REMOVAL OF SKIN LESION  Replace ... With benign 0.5cm or less
  Replace <RET>
benign 0.5cm or less
PRINT ORDER: 3
        Select a PROCEDURE: 11600          REMOVAL OF SKIN LESION
NAME: REMOVAL OF SKIN LESION  Replace ... With malig. 0.5cm or less
  Replace <RET>
malig. 0.5cm or less
PRINT ORDER: 6
        Select a PROCEDURE: <RET>
```

Ambulatory Surgery Check-Off Sheet Profile

DERMATOLOGY

CHARGE DISPLAYED	# OF COLUMNS	LINE FORMAT	ASSOCIATED CLINICS
YES	TWO VERTICAL	CODE/NAME/$	DERMATOLOGY

SUBHEADER	PRINT ORDER
REMOVAL OF SKIN LESION, TRUNK ARMS OR LEGS	3

```
--------------------------------------------------------------------------------
Select SUBHEADER: REMOVAL OF SKIN LESION, SCALP, NECK, HANDS
   ARE YOU ADDING 'REMOVAL OF SKIN LESION, SCALP, NECK, HANDS' AS A NEW AMBULATORY
SURG. CHECK-OFF SHEET PRINT FIELDS? Y  (YES)
NAME: REMOVAL OF SKIN LESION, SCALP, NECK, HANDS  Replace <RET>
PRINT ORDER: 6
```

Ambulatory Surgery Subheader Profile

REMOVAL OF SKIN LESION, SCALP, NECK, HANDS

CHECK-OFF SHEET	PRINT ORDER
DERMATOLOGY	6

PROCEDURES	PRINT ORDER	CHARGE

```
--------------------------------------------------------------------------------
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

EXAMPLE, cont.

```
        Select a PROCEDURE: 11420          REMOVAL OF SKIN LESION
NAME: REMOVAL OF SKIN LESION  Replace ... With benign 0.5cm or less
  Replace <RET>
benign 0.5cm or less
PRINT ORDER: 3
        Select a PROCEDURE: 11620          REMOVAL OF SKIN LESION
NAME: REMOVAL OF SKIN LESION  Replace ... With malig. .05cm or less
  Replace <RET>
   malig. .05cm or less
PRINT ORDER: 6
        Select a PROCEDURE: <RET>


                    Ambulatory Surgery Check-Off Sheet Profile

DERMATOLOGY

    CHARGE
    DISPLAYED  # OF COLUMNS     LINE FORMAT   ASSOCIATED CLINICS
    ---------  ------------     -----------   ------------------
       YES     TWO VERTICAL     CODE/NAME/$   DERMATOLOGY

    SUBHEADER                                                    PRINT ORDER
    ---------                                                    -----------
    REMOVAL OF SKIN LESION, TRUNK, ARMS, OR LEGS                       3
    REMOVAL OF SKIN LESION, SCALP, NECK, HANDS                         6

--------------------------------------------------------------------------------
Select SUBHEADER: <RET>
Print this SHEET? NO// Y  YES
This report requires a 132 column printer.
DEVICE: HOME// A137        HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)


Select Check-Off Sheet:
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Build CPT Check-off Sheet

EXAMPLE, cont.

Ambulatory Surgery Check -Off Sheet
CPT Codes for DERMATOLOGY

Date:

	REMOVAL OF SKIN LESION, TRUNK, ARMS, OR LEGS		
11400	benign 0.5cm or less		( )
11600	malig. 0.5cm or less		( )
11401	benign .06 to 1.0cm		( )
11601	malig. 0.6 to 1.0cm		( )
11402	benign 1.1 to 2.0cm		( )
11602	malig. 1.1 to 2.0cm		( )
11606	benign over 4.0cm		( )
11643	malig. 2.1 to 4.0cm		( )
11644	malig 3.1 to 4.0cm		( )
	REMOVAL OF SKIN LESION, SCALP, NECK, HANDS		
11420	benign 0.5cm or less		( )
11620	malig. .05cm or less		( )
11421	benign .06 to 1.0cm		( )
11621	malig. 0.6 to 1.0 cm		( )
11422	benign 1.1 to 20.cm		( )
11622	malig. 1.1 to 2.0cm		( )
11426	benign over 4.0cm	306.24	( )
	REMOVAL OF SKIN LESION, FACE, EARS, EYELIDS		
11440	benign 0.5cm or less		( )
11640	malig. 0.5cm or less		( )
11441	benign .06 to 1.0cm		( )
11641	malig 0.6 to 1.0cm		( )
11442	benign 1.1 to 2cm		( )
11642	malig 1.1 to 2cm		( )
11446	benign over 4.0cm	306.24	( )
11646	malig over 4.0cm		( )
	MISCELLANEOUS		
40654	repair lip	306.24	( )
11000	biopsy of lesion	666.40	( )
11101	biopsy of additional lesion		( )
11200	removal of skin (15)		( )
11201	removal of skin (over 15)		( )
11730	removal of plate	228.80	( )
12011	repair superficial wound		( )
17000	destruction of face lesion		( )
17001	destruction of face lesions 2&3		( )
17002	destruction of face lesions, over 3		( )
17100	destruction of skin lesion		( )
17102	destruction of skin lesions (2-15)		( )

	REMOVAL OF TUMOR		
21555	neck/chest		( )
23075	shoulder		( )
24075	upper arm/elbow		( )
25075	forearm/wrist		( )
26115	hand/finger		( )
27618	lower leg		( )
28043	foot		( )
	DRAIN		
10003	sebaceous cyst		( )
10101	infected nail (s)		( )
10141	hematoma	306.24	( )
	CLEANSIN G		
11000	surgical of skin	666.40	( )
11001	each add 10%		( )
11042	debridement skin subq	306.24	( )
	T RIM		
11050	skin lesion (1)		( )
11051	skin lesion (2-4)		( )
11052	skin lesion (over 4)		( )
	REMOVAL		
11731	second nail plate	306.24	( )
11750	nail bed	352.00	( )
11752	nail bed/fingertip		( )
	CLOS URE		
12020	split wound (simple)	666.40	( )
12021	split wound (packing)	685.52	( )

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Ambulatory Surgery Rate Edit

INTRODUCTION

The Ambulatory Surgery Rate Edit option allows you to enter or edit entries in the CPT RATE GROUP BILLING file.

The CPT/HCFA (Current Procedural Terminology/Health Care Finance Administration) code, description, current OPC status, effective date, billing status, billing group, primary division, and charge for the selected procedure are displayed; however, only the effective date, status (status for the billing rate group on or after the effective date), and billing group (the OPT Medicare rate group assigned to this procedure on/after the effective date) are editable.

The chart beginning on the following page shows the prompts and steps involved in using the Ambulatory Surgery Rate Edit option.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Ambulatory Surgery Rate Edit

PROCESS
The following chart shows the prompts and steps involved in using the Ambulatory Surgery Rate Edit option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select AMBULATORY SURGERY PROCEDURE:	.CPT code/procedure you wish to enter/edit	2
		.<??> for a list	1
		.<RET> or up-arrow <^>	7
2	An ambulatory surgery procedure billing profile is displayed providing the CPT/HCFA code, description, current OPC status, effective date, billing status, billing group, division, and charge for the selected procedure. Only the date, status, and billing group are editable. If you arrive at this step after editing, the new values are displayed. At the first occurrence of this step, you will proceed to Step 3. For subsequent occurrences, you will return to Step 1.		1 or 3
	If a new effective date is entered at this step, an additional prompt "Are you adding a new RATE GROUP entry to this PROCEDURE?" will also appear.		
3	Select PROCEDURE EFFECTIVE DATE:	.select, by effective date, the procedure you wish to edit	4
		.new date (to add a new rate group entry to this procedure)	4
		.<RET> (first occurrence of this prompt)	1
		.<RET> (subsequent occurrences of this prompt)	2
	Entry of a different date at this prompt will not create a new effective date. It will change the effective date you selected at Step 3.		
4	EFFECTIVE DATE: {date}//	.<RET> to accept default	5
		.other date	5
		.<@> to delete the entire entry	3

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Ambulatory Surgery Rate Edit

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Defaults will appear for Steps 5 and 6 only if you are editing an existing entry.		
	The entry at this prompt is the status for the billing rate group on or after the effective date.		
*5	STATUS: {status}//	.<RET> to accept default if ACTIVE	6
		.<RET> to accept default if INACTIVE	3
		.1 or ACTIVE	6
		.0 or INACTIVE	3
	The entry at this prompt is the OPT Medicare rate group assigned to this procedure on/after the effective date.		
*6	RATE GROUP: {group}//	.<RET> to accept default	3
		.other rate group (enter RATE 1, RATE 2, etc.)	3
		.<??> for a list	6
7	Return to the menu.		

*Required field.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Ambulatory Surgery Rate Edit

EXAMPLE
The following is an example of what might appear on your screen while using the Ambulatory Surgery Rate Edit option. User responses are shown in boldface type.

```
Select AMBULATORY SURGERY PROCEDURE: 10080         DRAINAGE OF PILONIDAL CYST
         ...OK? YES// <RET>  (YES)

CPT/HCFA Code                                                Current OPC Status
--------------                                               ------------------
10080 - DRAINAGE OF PILONIDAL CYST                            NATIONALLY ACTIVE

    INCISION AND DRAINAGE OF PILONIDAL CYST;
    SIMPLE

 Effective Date  Billing Status  Billing Group         Division        Charge
 --------------  --------------  --------------        --------        ------
 JAN  1,1991     ACTIVE          OPT MEDICARE RATE 1   ALBANY          234.00

-------------------------------------------------------------------------------
Select PROCEDURE EFFECTIVE DATE:  3/1  (MAR 01, 1992)
Are you adding a new RATE GROUP entry to this PROCEDURE? Y  YES
EFFECTIVE DATE: MAR 1,1992// <RET>
STATUS: INACTIVE

Select PROCEDURE EFFECTIVE DATE: <RET>
Ambulatory Surgery Procedure Billing Profile

CPT/HCFA Code                                                Current OPC Status
--------------                                               ------------------
10080 - DRAINAGE OF PILONIDAL CYST                            NATIONALLY ACTIVE

    INCISION AND DRAINAGE OF PILONIDAL CYST;
    SIMPLE

 Effective Date  Billing Status  Billing Group         Division        Charge
 --------------  --------------  --------------        --------        ------
 JAN  1,1991     ACTIVE          OPT MEDICARE RATE 1   ALBANY          234.00
 MAR  1,1992     INACTIVE                              ALBANY

-------------------------------------------------------------------------------

Select AMBULATORY SURGERY PROCEDURE: <RET>
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Check off Sheet Print

INTRODUCTION

This option allows you to print Ambulatory Surgery Check-Off Sheets that have been set up through the Build CPT Check-off Sheet option. The check-off sheets printed through this option are generic and may therefore be used for any patient. A space is provided in the upper left corner for the patient card imprint.

A check-off sheet is not necessarily associated with a particular clinic and may be used for several clinics.

This report requires 132 columns.

Due to the brevity of this option, no process chart is provided.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Check off Sheet Print

EXAMPLE
Below is an example of what may appear on your screen while using the Check off Sheet Print option. User responses are shown in boldface type. A sample output is provided on the following page.

```
                        Print Clinic Check-Off Sheet


Select AMBULATORY CHECK-OFF SHEET NAME: DERMATOLOGY
         ...OK? YES// <RET>  (YES)
Select AMBULATORY CHECK-OFF SHEET NAME: <RET>

This report requires a 132 column printer.
DEVICE: HOME// A137          HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Check off Sheet Print

EXAMPLE, cont.

Ambulatory Surgery Check -Off Sheet
CPT Codes for DERMATOLOGY

Date:

REMOVAL OF SKIN LESION, TRUNK, ARMS, OR LEGS

11400	benign 0.5cm or less		( )
11600	malig. 0.5cm or less		( )
11401	benign .06 to 1.0cm		( )
11601	malig. 0.6 to 1.0cm		( )
11402	benign 1.1 to 2.0cm		( )
11602	malig. 1.1 to 2.0cm		( )
11606	benign over 4.0cm		( )
11643	malig. 2.1 to 4.0cm		( )
11644	malig 3.1 to 4.0cm		( )

REMOVAL OF SKIN LESION, SCALP, NECK, HANDS

11420	benign 0.5cm or less		( )
11620	malig. .05cm or less		( )
11421	benign .06 to 1.0cm		( )
11621	malig. 0.6 to 1.0 cm		( )
11422	benign 1.1 to 20.cm		( )
11622	malig. 1.1 to 2.0cm		( )
11426	benign over 4.0cm	306.24	( )

REMOVAL OF SKIN LESION, FACE, EARS, EYELIDS

11440	benign 0.5cm or less		( )
11640	malig. 0.5cm or less		( )
11441	benign .06 to 1.0cm		( )
11641	malig 0.6 to 1.0cm		( )
11442	benign 1.1 to 2cm		( )
11642	malig 1.1 to 2cm		( )
11446	benign over 4.0cm	306.24	( )
11646	malig over 4.0cm		( )

MISCELLANEOUS

40654	repair lip	306.24	( )
11000	biopsy of lesion	666.40	( )
11101	biopsy of additional lesion		( )
11200	removal of skin (15)		( )
11201	removal of skin (over 15)		( )
11730	removal of plate	228.80	( )
12011	repair superficial wound		( )
17000	destruction of face lesion		( )
17001	destruction of face lesions 2&3		( )
17002	destruction of face lesions, over 3		( )

REMOVAL OF TUMOR

21555	neck/chest		( )
23075	shoulder		( )
24075	upp er arm/elbow		( )
25075	forearm/wrist		( )
26115	hand/finger		( )
27618	lower leg		( )
28043	foot		( )

DRAIN

10003	sebaceous cyst		( )
10101	infected nail (s)		( )
10141	hematoma	306.24	( )

CLEANSING

11000	surgical of skin	666.40	( )
11001	each add 10%		( )
11042	debridement skin subq	306.24	( )

TRIM

11050	skin lesion (1)		( )
11051	skin lesion (2 -4)		( )
11052	skin lesion (over 4)		( )

REMOVAL

11731	second nail plate	306.24	( )
11750	nail bed	352.00	( )
11752	nail bed/fingertip		( )

CLOSURE

12020	split wound (simpl e)	666.40	( )
12021	split wound (packing)	685.52	( )

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Run Amb. Surg. Update

INTRODUCTION

The Run Amb. Surg. Update option is used to transfer CPT codes from the temporary UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) to the permanent BILLABLE AMBULATORY SURGICAL CODE file (#350.4). The UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) was created at the Albany ISC and was forwarded initially with the release of Integrated Billing version 1.5. Subsequent updated files will also be created and forwarded from Albany each time there is a new HCFA (Health Care Finance Administration) update, approximately once a year.

As entries are created in the BILLABLE AMBULATORY SURGICAL CODE file (#350.4), they are also created in the AMBULATORY PROCEDURE file (#409.71) for any code that does not already exist in this file.

The number of codes that already have entries for the given effective date and codes unable to transfer will be displayed upon completion of the transfer. The number of codes unable to transfer will include the number of codes that already have entries for the given effective date. These numbers should be low unless this is not the first time you are transferring the entries for the effective date and you did not purge the successfully transferred entries through the Purge Update File option after the initial transfer. In this case, the total number of codes that were successfully transferred initially will be listed this time under "Codes already have entries for given effective date" and "Codes unable to transfer".

For a list of all entries not successfully transferred and the reason why, you may run the List Transfer Errors option under this menu.

Due to the brevity of this option, no process chart is provided.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Run Amb. Surg. Update

EXAMPLE
The following is an example of what might appear on your screen while using this option. User responses are shown in boldface type.

```
Transfer HCFA updates to the Permanent BASC File


This option transfers the HCFA updates from the temporary BASC file to the
permanent BASC file.
Proceed with transfer? Y  YES

Beginning transfer, this could take some time.   Please wait...

Transferring HCFA updates to permanent BASC file.

Transfer complete: 923 Entries created  in 409.71
                   91 Entries created in 350.4
                   91 Entries in 350.4 "stuffed"

                   0 Codes already have entries for given effective date
                   9 Codes unable to transfer
```

MCCR System Definition Menu
Enter/Edit Billing Rates

Entry/edit of the REVENUE CODE RATES is no longer allowed. If selected, the following message is displayed, "This option is no longer active. Please use the Enter/Edit Charge Master option."

 This option is locked with the IB SUPERVISOR security key.

Introduction

The Enter/Edit Billing Rates option is used to edit billing rates for per diem rates; the Medicare deductible (this is the only place the Medicare deductible is entered); the HCFA ambulatory surgery rates, pharmacy copayment amounts, and CHAMPVA subsistence rates that are used in the automatic calculation of costs when preparing a third party bill.

Although the option allows entry of new rates, it should only be used for editing and for the entry of duplicate rates. Duplicate rates are those where two different rates are used for the same revenue code/bedsection/effective date dependent on payor. All other new billing rates should be entered through the Fast Enter New Billing Rates option.

If YES is answered at the "NON-STANDARD RATE" prompt, that billing rate will only be used with insurance companies where the selected revenue code has been listed in the DIFFERENT REVENUE CODES TO USE field of the INSURANCE COMPANY file.

You may enter an additional amount as well as the basic amount to be charged for all rates. This is a fixed additional dollar amount that will be added to the basic charge after it has been computed. An example would be the additional charge of $200 added to HCFA Ambulatory Surgery rate groups for inter-ocular lens implants.

Accuracy in entering billing rates is critical. Incorrect entries will result in erroneous bills. After new rates are entered, it is suggested you print the Billing Rates List (Billing Rates List option on the Management Reports Menu) to verify that all entries are correctly recorded.

MCCR System Definition Menu
Enter/Edit Billing Rates

Example

```
                          Enter/Edit Billing Rates

CHOOSE FROM:
    1               REVENUE CODE RATES
    2               PER DIEM RATES
    3               MEDICARE DEDUCTIBLE
    4               HCFA AMB. SURG. RATES
    5               RX CO-PAYMENT
    6               CHAMPVA SUBSISTENCE RATES


Select Billing Rate Type: 1  REVENUE CODE RATES

Select BEDSECTION: 1   ALCOHOL AND DRUG TREATMENT   8

Select BILLING RATE EFFECTIVE DATE: 10 1 90   OCT  1, 1990  ALCOHOL AND DRUG
TREATMENT   101   $250.00   YES,ACTIVE
EFFECTIVE DATE: OCT 1,1990// <RET>
BILLING BEDSECTION: ALCOHOL AND DRUG TREATMENT// <RET>
REVENUE CODE: 101// <RET>
AMOUNT: $450.00// 400.00
ACTIVE: YES,ACTIVE// <RET>
PAYORS TO USE WITH: INSURANCE CO.// <RET>
NON-STANDARD RATE: <RET>

Select BILLING RATE EFFECTIVE DATE: "10 1 90"   OCT 01,1990
   ARE YOU ADDING 'OCT 1,1990' AS A NEW BILLING RATES? Y   (YES)
EFFECTIVE DATE: OCT 1,1990// <RET>
BILLING BEDSECTION: ALCOHOL AND DRUG TREATMENT// <RET>
REVENUE CODE: 101   101  ALL INCL R&B  ALL INCLUSIVE ROOM & BOARD
AMOUNT: 350.00
ACTIVE: 1   YES,ACTIVE
PAYORS TO USE WITH: opc  ALL BUT INSURANCE CO.'S
NON-STANDARD RATE: <RET>

Select BILLING RATE EFFECTIVE DATE: <RET>

Select BEDSECTION: <RET>
```

MCCR System Definition Menu
Enter/Edit Billing Rates

Example, cont.

```
                          Enter/Edit Billing Rates

CHOOSE FROM:
    1               REVENUE CODE RATES
    2               PER DIEM RATES
    3               MEDICARE DEDUCTIBLE
    4               HCFA AMB. SURG. RATES
    5               RX CO-PAYMENT
    6               CHAMPVA SUBSISTENCE RATES


Select Billing Rate Type:
```

MCCR System Definition Menu
Flag Stop Codes/Dispositions/Clinics

INTRODUCTION

Outpatient encounters which are recorded in the Scheduling package as either registrations or "stand-alone" stop codes will be billed automatically as those events are checked out. The Flag Stop Codes/Dispositions/Clinics option is used to flag/unflag those stop codes and dispositions which should not be billed. The option may also be used to flag clinics where Means Test billing is not appropriate.

If you make more than one selection, you will be given the opportunity to review the selections and deselect any, if necessary. All selections will be assigned the same effective date and billable status.

Note that once a selection has been flagged as non-billable, it may later be flagged as billable if it is subsequently determined it would be appropriate to continue billing.

Although this option is not locked, the MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

The chart beginning on the following page shows the prompts and steps involved in using this option.

MCCR System Definition Menu
Flag Stop Codes/Dispositions/Clinics

PROCESS
The following chart shows the prompts and steps involved in using the Flag Stop Codes/Dispositions/Clinics option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	"This option is used to set up Clinic Stop Codes, Dispositions, and Clinics as either non-billable or billable for the Means Test Outpatient Copayment. Use of this option will have an immediate effect on your billing operation, so you should have your work pre-planned before using this option." Select one of the following: S STOP CODES D DISPOSITIONS C CLINICS		
	Enter your choice:	.S, D, or C	2
		.<RET>	6
2	"You may now enter the dispositions that you wish to flag. Please note all dispositions that you select will be assigned the same effective date and billable status."		
	Select {STOP CODE/ DISPOSITION/CLINIC}:	.stop code, disposition, or clinic	2
		.<RET> when all choices have been entered	3
	If you have made more than one selection, you will be given the opportunity to review your selections at this point and deselect any item.		
3	Ignore Means Test billing for this {stop code/disposition/clinic}:	.YES to ignore Means Test billing for this selection	4
		.NO to activate Means Test billing for this selection	4
4	Please enter the effective date to {activate/ignore} billing:	.date	5
		.<RET>	1

MCCR System Definition Menu
Flag Stop Codes/Dispositions/Clinics

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
5	"Action to take => {activate/ignore} billing for the following {stopcodes/dispositions/clincis}: {STOP CODES/DISPOSITIONS/CLINICS selected}"		
	Is it okay to proceed and file these entries?	.YES	1
		NO	1
6	Return to the menu.		

MCCR System Definition Menu
Flag Stop Codes/Dispositions/Clinics

EXAMPLE, cont.

```
      Flag Stop Codes, Dispositions, and Clinics for Means Test Billing
================================================================================
This option is used to set up Clinic Stop Codes, Dispositions, and Clinics
as either non-billable or billable for the Means Test Outpatient Copayment.

Use of this option will have an immediate effect on your billing operations,
so you should have your work pre-planned before using this option.
================================================================================

     Select one of the following:

          S         STOP CODES
          D         DISPOSITIONS
          C         CLINICS

Enter your choice:
```

MCCR System Definition Menu
Flag Stop Codes/Clinics for Third Party

INTRODUCTION This option is used to flag stop codes and clinics as *non-billable* or *non-auto billable.*

Non-billable stop codes or clinics are those that should not be billed to a Third Party payer. By default, if a stop code or clinic is non-billable, it will not be billed by the auto biller; and therefore, is non-auto billable.

Non-auto billable stop codes or clinics are those that may be billable to a Third Party payer, but the auto biller should not be used for billing. These are visits that may need more research than can be performed by the auto biller to determine if they *are* billable.

These parameters are flagged by date and may be inactivated and reactivated.

MCCR System Definition Menu
Flag Stop Codes/Clinics for Third Party

EXAMPLE
The following example is an example of what may appear on your screen while using this option. User responses appear in boldface type.

```
Flag Stop Codes and Clinics for Third Party Billing
============================================================================
FOR THIRD PARTY BILLING, THIS OPTION IS USED TO SET UP:
1. INDIVIDUAL OR A GROUP OF STOP CODES OR CLINICS AS:
   a. NON-BILLABLE OR BILLABLE.
      A Stop/Clinic is assumed billable until it is flagged as non-billable.
   b. IGNORED BY THE AUTO BILLER.  Stops the auto biller from creating
      bills for specified billable Stops/Clinics.
2. ALL CLINICS TO BE:
   a. IGNORED BY THE AUTO BILLER.  Stops the auto biller from creating bills
      for ALL clinics.  Should only be used if the outpatient auto biller
      is on but only a small number of Clinics should be auto billed.
   b. BILLED BY THE AUTO BILLER.  Resets all Clinics to be auto billed.
Use of this option will have an immediate effect on your billing operations
so you should have your work pre-planned before using this option.
====================================== ====================================

     Select one of the following:

          S         STOP CODES
          C         CLINICS
          A         ALL CLINICS

Enter your choice: STOP CODES

========================================================== ====================
You may now enter the clinic stop codes that you wish to flag.  Please note
all clinic stop codes that you select will be assigned the same effective
date and billable status and auto bill status.
====================================== =====================================

Select CLINIC STOP CODE: GENERAL MEDICINE          301
Next CLINIC STOP CODE: <RET>

Is this clinic stop code Non-Billable for Third Party Billing? NO

Should the Third Party Auto Biller create bills for this clinic stop code? NO
Please enter the date this should become effective:  T  (OCT 01, 1996)

============================================================================
GENERAL MEDICINE

Effective Oct 01, 1996 the above clinic stop codes will be billable
and will NOT have bills created by the Third Party auto biller.

Is this correct, is it okay to proceed and file these entries?  YES

Filing these CLINIC STOP CODE entries...  . done!
```

MCCR System Definition Menu
Insurance Company Entry/Edit

Now displays NO for ALLOW MULTIPLE BEDSECTIONS only if the field has been answered NO. Previously, NO was assumed if there was no answer in the field.

The Billing Parameters action of this option has been modified so that the user may enter the BIN number for an insurance carrier. This number ID is also displayed in the Insurance Company Editor screen. The BIN number must be entered for the company which is the Tricare FI (Fiscal Intermediary - the company with which the Tricare patient holds their Tricare insurance coverage). The BIN number is passed to the RNA package and transmitted to the electronic switch company, where it is used to determine the address for forwarding to the FI. If the BIN number is not entered, pharmacy claims will not be passed to the RNA system for submission to the FI.

Only national, print-type forms may be selected at the FORM TYPE field. A locally defined form name cannot be selected. The FORM TYPE field is used to determine the basic bill format, not the specific form that will print for the insurance company.

Introduction

The Insurance Company Entry/Edit option is used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies. An insurance company must be in the INSURANCE COMPANY file before it can be entered into a patient's record.

When entering new insurance companies, you will be prompted for the company street address, city, and whether or not the company will reimburse for treatment.

Following is a listing of the actions found on the screen in this option and a brief description of each. Once an action has been selected, <??> may be entered at most of the prompts that appear for lists of acceptable responses or instruction on how to respond.

Insurance Company Editor Screen

Once the insurance company is selected, this screen is displayed listing the following groups of information for that company: billing parameters, main mailing address, inpatient claims office data, outpatient claims office data, prescription claims office data, appeals office data, inquiry office data, remarks, and synonyms.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

BP Billing Parameters - Allows you to add/edit the billing parameters for the selected insurance company.

MM Main Mailing Address - Allows you to add/edit the company's main mailing address. The address entered here will automatically be entered for the other office addresses.

IC Inpt Claims Office - Allows you to add/edit the company's inpatient claims office name, address, phone and fax numbers.

OC Opt Claims Office - Allows you to add/edit the company's outpatient claims office name, address, phone and fax numbers.

PC Prescr Claims Of - Allows you to add/edit the company's prescription claims office name, address, phone and fax numbers.

AO Appeals Office - Allows you to add/edit the company's appeals office name, address, phone and fax numbers.

IO Inquiry Office - Allows you to add/edit the company's inquiry office name, address, phone and fax numbers.

RE Remarks - Allows the user to enter comments concerning the selected insurance company.

SY Synonyms - Allows you to add/edit any synonyms for the selected company.

EA Edit All - Lists editable fields line by line for quick data entry.

AI (In)Activate Company - Allows you to activate/inactivate the selected insurance company. This may be used to inactivate duplicate companies in the system. When an insurance company is no longer valid, it is important to inactivate the company rather than delete it from the system. The IB INSURANCE SUPERVISOR security key is required. Once a company has been inactivated, it may not be selected when entering billing information.

You may also obtain a report of patients insured by a given company through this action.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

CC Change Insurance Co. - Allows you to change to another company without returning to the beginning of the option.

DC Delete Company - Allows you to delete an entry from the INSURANCE COMPANY (#36) file. If claims have been submitted to the company, another company must be selected in which to point all claims and receivables information.

PL Plans (accesses Insurance Plan List screen) - Allows you to display and change plan attributes associated with the insurance company.

Insurance Plan List Screen
This screen lists all plans (active and inactive, group and individual) for the selected insurance company.

Actions

VP View/Edit Plan (accessesView/Edit Plan screen) - Allows you to display /change plan detailed information.

IP Inactive Plan - Allows you to inactivate an insurance plan, or move subscribers from multiple insurance plans into one master plan.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

Annual Benefits Editor Screen
Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

IP Inpatient - Allows entry/edit of inpatient benefits data.

OP Outpatient - Allows entry/edit of outpatient benefits data.

MH Mental Health - Allows entry/edit of mental health inpatient and outpatient benefits data.

HH Home Health - Allows entry/edit of home health care benefits data.

HS Hospice - Allows entry/edit of hospice benefits data.

RH Rehab - Allows entry/edit of rehabilitation benefits data.

IV IV Mgmt. - Allows entry/edit of intravenous management benefits data.

EA Edit All - Lists editable fields line by line for quick data entry.

CY Change Year - Allows you to change to another benefit year.

View/Edit Plan Screen
This screen displays plan information for viewing/editing including utilization review info, plan coverage limitations, annual benefit dates, user information, and plan comments.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

UI UR Info - Allows entry/edit of utilization review information.

CV Add/Edit Coverage - Allows you to add or edit coverage limitations for a specific plan.

PC Plan Comments - Allows editing of comments for the plan.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

IP Inpatient - Allows entry/edit of inpatient benefits data.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

CP Change Plan - Allows you to select another plan for this insurance company without having to exit back to the previous screen.

Although this option is not locked, the MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

Example

```
Insurance Company Editor    May 30, 1997 10:32:43     Page:    1 of    5
Insurance Company Information for: FOUNDATION HEALTH
Type of Company: CHAMPUS                     Currently Active

                            Billing Parameters
  Signature Required?: NO                    Attending Phys. ID:
           Reimburse?: WILL REIMBURSE        Hosp. Provider No.:
    Mult. Bedsections:                        Primary Form Type:
     Diff. Rev. Codes:                             Billing Phone:
       One Opt. Visit: NO                    Verification Phone:
  Amb. Sur. Rev. Code:                      Precert Comp. Name:
  Rx Refill Rev. Code:                           Precert  Phone:
    Filing Time Frame:                             Bin Number:



+         Enter ?? for more actions                                    >>>
BP  Billing Parameters    AO  Appeals Office        AI  (In)Activate Company
MM  Main Mailing Address  IO  Inquiry Office        CC  Change Insurance Co.
IC  Inpt Claims Office    RE  Remarks               DC  Delete Company
OC  Opt Claims Office     SY  Synonyms              PL  Plans
PC  Prescr Claims Of      EA  Edit All              EX  Exit
Select Action: Next Screen// BP   Billing Parameters


SIGNATURE REQUIRED ON BILL?: NO// <RET>
REIMBURSE?: WILL REIMBURSE// <RET>
ALLOW MULTIPLE BEDSECTIONS: <RET>
DIFFERENT REVENUE CODES TO USE: <RET>
ONE OPT. VISIT ON BILL ONLY: <RET>
AMBULATORY SURG. REV. CODE: <RET>
PRESCRIPTION REFILL REV. CODE: <RET>
```

MCCR System Definition Menu
Insurance Company Entry/Edit

Example, cont.

```
BIN NUMBER: ??
     This field is used for facilities who are billing CHAMPUS prescription
     charges electronically to the CHAMPUS fiscal intermediary.  The Bin
     number identifies this company as the CHAMPUS FI to the electronic
     billing system so that the claim is correctly routed to the FI.
BIN NUMBER: <RET>
FILING TIME FRAME: <RET>
FILING TIME FRAME: <RET>
ATTENDING PHYSICIAN ID.: <RET>
HOSPITAL PROVIDER NUMBER: <RET>
FORM TYPE: <RET>
TYPE OF COVERAGE: INDEMNITY// <RET>
BILLING PHONE NUMBER: 518-272-1000// <RET>
VERIFICATION PHONE NUMBER: <RET>
Are Precerts Processed by Another Insurance Co.?: NO
         // <RET>
PRECERTIFICATION PHONE NUMBER: <RET>.....
```

MCCR System Definition Menu
List Flagged Stop Codes/Dispositions/Clinics

INTRODUCTION

The List Flagged Stop Codes/Dispositions/Clinics option is used to generate a listing of all stop codes, dispositions, and clinics which have been flagged as not being billable for Means Test billing.

You will be prompted for the effective date of the list and a device. The output contains a separate page for non-billable dispositions, stop codes, and clinics.

The MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

Due to the brevity of this option, a process chart is not provided.

MCCR System Definition Menu
List Flagged Stop Codes/Dispositions/Clinics

EXAMPLE
The following is an example of what may appear on your screen while using the List Flagged Stop Codes/Dispositions/Clinics option followed by an example of the output. When actually printed each category will appear on a separate page. User responses appear in boldface type.

```
     This report may be used to generate a list of all clinic stop codes,
     dispositions, and clinics where Means Test billing will be ignored.

Please select the effective date for this list: DEC 16, 1993// <RET> (DEC 16, 1993)
DEVICE: HOME// A200          RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// <RET>  (DEC 16, 1993@08:23:37)

This job has been queued.  The task number is 13395.



==========================================================================
                      LIST OF NON-BILLABLE DISPOSITIONS
                                As Of: 12/16/93
                                                              Page: 1
                                                         Run Date: 12/16/93
==========================================================================

DEAD ON ARRIVAL



==========================================================================
                    LIST OF NON-BILLABLE CLINIC STOP CODES
                                As Of: 12/16/93
                                                              Page: 2
                                                         Run Date: 12/16/93
========================================================================== ==

EMPLOYEE HEALTH



==========================================================================
                         LIST OF NON-BILLABLE CLINICS
                                As Of: 12/16/93
                                                               Page: 3
                                                         Run Date: 12/16/93
==========================================================================

ALLERGY RESEARCH
```

MCCR System Definition Menu
List Flagged Stop Codes/Clinics for Third Party

INTRODUCTION

This output is used to generate a list of all stop codes and clinics that are flagged through the Flag Stop Codes/Clinics for Third Party option as *non-billable* or *non-auto billable.* These flags can be deactivated and reactivated through the above mentioned option.

Non-billable stop codes or clinics are those that should not be billed to a Third Party payer. By default, if a stop code or clinic is non-billable, it will not be billed by the auto biller; and therefore, is non-auto billable.

Non-auto billable stop codes or clinics are those that may be billable to a Third Party payer, but the auto biller should not be used for billing. These are visits that may need more research than can be performed by the auto biller to determine if they *are* billable.

MCCR System Definition Menu
List Flagged Stop Codes/Clinics for Third Party

EXAMPLE
The following example is an example of what may appear on your screen while using this option. User responses appear in boldface type.

```
     This report may be used to generate a list of all clinic stop codes,
     and clinics that are non-billable in Third Party Billing or
     that will not have bills created by the Third Party Auto Biller.

Please select the effective date for this list: OCT 01, 1996// <RET> (OCT 01, 1996)
DEVICE: HOME// <RET>  LAT    RIGHT MARGIN: 80// <RET>

================================================================================
           LIST OF CLINIC STOP CODES FLAGGED FOR THIRD PARTY BILLING
                              As Of: 10/01/96
                                                              Page: 1
                                                          Run Date: 10/01/96
================================================================================


                                  NON-BILLABLE

AMPUTATION CLINIC                       CARDIAC SURGERY
CARDIOVASCULAR NUCLEAR MED              CWT SUBSTANCE ABUSE
CWT/TR-HCMI                             CWT/TR-SUBSTANCE ABUSE
EMPLOYEE HEALTH                         ENT
RMS COMPENSATED WORK THERAPY            RMS COMPENSATED WORK THERAPY
RMS INCENTIVE THERAPY                   RMS INCENTIVE THERAPY
RMS VOCATIONAL ASSISTANCE               RMS VOCATIONAL ASSISTANCE
TELEPHONE TRIAGE                        TELEPHONE/ALCOHOL DEPENDENCE
TELEPHONE/ANCILLARY                     TELEPHONE/DENTAL
TELEPHONE/DIAGNOSTIC                    TELEPHONE/DIALYSIS
TELEPHONE/DRUG DEPENDENCE               TELEPHONE/GENERAL PSYCHIATRY
TELEPHONE/MEDICINE                      TELEPHONE/PROSTHETICS/ORTHOTIC

Enter RETURN to continue or '^' to exit: <RET>

================================================================================
           LIST OF CLINIC STOP CODES FLAGGED FOR THIRD PARTY BILLING
                              As Of: 10/01/96
                                                              Page: 2
                                                          Run Date: 10/01/96
================================================================================
TELEPHONE/PTSD                          TELEPHONE/REHAB AND SUPPORT
TELEPHONE/SPECIAL PSYCHIATRY            TELEPHONE/SUBSTANCE ABUSE
TELEPHONE/SURGERY

                                NOT AUTO BILLED

GENERAL MEDICINE


Enter RETURN to continue or '^' to exit: <RET>
```

MCCR System Definition Menu
List Flagged Stop Codes/Clinics for Third Party

EXAMPLE, cont.

```
================================================================================
                LIST OF CLINICS FLAGGED FOR THIRD PARTY BILLING
                              As Of: 10/01/96
                                                                  Page: 3
                                                            Run Date: 10/01/96
============================================================ ================

                                    NON-BILLABLE

No clinics are flagged as NON-BILLABLE

                                  NOT AUTO BILLED

GENERAL MEDICAL
```

MCCR System Definition Menu
Billing Rates List

The Third Party Tortiously Liable rates have been removed from this report. These rates are now available on the Charge Item Report on the Print Charge Master option.

Introduction

The Billing Rates List option will print a list of billing rates for a selected date range. It is an efficient way to verify that all billing rate entries have been entered correctly.

The output generated by this option displays the CHAMPVA, Health Care Finance Administration (HCFA) ambulatory surgery rates, Medicare deductible, and copayments. The effective date, amount (basic rate), and additional amount will be shown for each rate, if applicable. Certain ambulatory surgeries may be billed at the HCFA rate. The amount shown (if any) in the "Additional Amount" column is an extra amount which may be charged for all procedures within that rate group. The amount shown under "Inpatient Per Diem" and "NHCU Per Diem" is the daily charge for Category C patients.

Any billing rate that is effective for any date within the selected range is displayed. If more than one rate was effective within the date range, both rates are displayed.

MCCR System Definition Menu
Billing Rates List

Example

```
Enter Beginning Date: 1/1  (JAN 01, 1997)
Enter Ending Date: t  (JUN 11, 1997)
DEVICE: HOME// <RET>  LAT    RIGHT MARGIN: 80// <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 1
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
================================================================================

CHAMPVA LIMIT
  Effective Date      Amount    Additional Amount
  OCT 01, 1991        $25

CHAMPVA SUBSISTENCE
  Effective Date      Amount    Additional Amount
  OCT 01, 1994        $9.50
HCFA AMB. SURG. RATE 1
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $285

HCFA AMB. SURG. RATE 2
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $382



Enter RETURN to continue or '^' to exit: <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 2
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
============================================================ ==================

HCFA AMB. SURG. RATE 3
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $438

HCFA AMB. SURG. RATE 4
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $539

HCFA AMB. SURG. RATE 5
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $615

HCFA AMB. SURG. RATE 6
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $580      $200



Enter RETURN to continue or '^' to exit: <RET>
```

MCCR System Definition Menu
Billing Rates List

Example, cont.

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 3
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
========================================================================

HCFA AMB. SURG. RATE 7
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $853

HCFA AMB. SURG. RATE 8
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $705      $200

HCFA AMB. SURG. RATE 9
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $0

INPATIENT PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $10



Enter RETURN to continue or '^' to exit:

JUN 11,1997       ***Billing Rates Listing***                    PAGE 4
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
============================================================== ================

MEDICARE DEDUCTIBLE
  Effective Date      Amount    Additional Amount
  JAN 01, 1996        $736

NHCU PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $5

NSC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1992        $2
  JUN 09, 1997        $5.00     $2.00

SC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $2


Enter RETURN to continue or '^' to exit:
```

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

INTRODUCTION The MCCR Site Parameter Enter/Edit option allows the user to define and edit the MCCR site specific billing parameters. The parameters are displayed upon entering the option. They are divided into groups for editing. Each group is labeled with a number to the left of the data items. Some values may be filled in by the system.

Group 1 The medical center name is automatically filled in and is not editable. The federal tax number is the tax ID# assigned to the medical center and is a required field. There may be more than one Blue Cross/Blue Shield provider number assigned to a site for different categories of care. The main Blue Cross/Blue Shield provider number should be entered here. This is a required field. The Medicare provider number is furnished to your facility by Medicare. The MAS Service Pointer is Medical Administration Service the way it is entered in your HOSPITAL SERVICE file. The default division will appear as the default to the division question when entering Billable Ambulatory Surgical Codes on a bill.

Group 2 The name and title of bill signer will appear on the third party billing form. The billing supervisor name does not appear on the form. This is used in conjunction with the Bill Cancellation and Bill Disapproval Mail Groups. If these groups are not specified, the billing supervisor will be one of the few recipients of both messages.

Group 3 The MULTIPLE FORM TYPES parameter should be set to YES if your facility uses more than one health insurance billing form. UB forms and HCFA-1500 are the forms currently available. If this field is left blank or answered NO, only UB forms will be allowed. Beginning with version 1.5 of Integrated Billing, the review step of creating a bill has been eliminated. If the CAN INITIATOR AUTHORIZE parameter is set to YES and the initiator holds the IB AUTHORIZE security key, the initiator of the bill will be allowed to authorize the bill. If this parameter is set to NO, another user who holds the IB AUTHORIZE key will have to authorize the bill.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

INTRODUCTION, cont.

Group 3, cont.

The CAN CLERK ENTER NON-PTF CODES parameter affects editing of diagnosis and procedure codes on inpatient bills. If this parameter is set to YES, diagnosis and procedure codes not found in the PTF record may be entered into the billing record. The ASK HINQ IN MCCR parameter, if set to YES, will allow the billing clerk to enter a request in the HINQ Suspense file while entering a bill for a patient whose eligibility has not been verified. If set to YES, the USE OP CPT SCREEN parameter will allow the Current Procedural Terminology Codes Screen for outpatient bills to be displayed on Billing Screen 5. The date range of this listing will be determined by the OP VISIT DATE(S) on file in the bill. If there are none, the STATEMENT COVERS FROM and TO dates will be used to determine which CPT codes can be selected for inclusion in the bill.

When billing Billable Ambulatory Surgical Codes (BASC), the entry at the DEFAULT AMB SURG REV CODE parameter will be the default revenue code stored in the bill. If this is not appropriate for any particular insurance company, the AMBULATORY SURG. REV. CODE field in the INSURANCE COMPANY file may be entered and used for that particular insurance company entry.

CPT procedures may be stored as ambulatory procedures in the SCHEDULING VISITS file (using the Add/Edit Stop Code option), and they may be stored in the billing record as procedures to print on a bill. There is now a two way sharing of information between these two files. If the TRANSFER PROCEDURES TO SCHED parameter is answered YES, as CPT procedures that are also ambulatory procedures are entered into a bill, the user will be prompted to indicate whether they should also be transferred to the SCHEDULING VISITS file. Conversely, the USE OP CPT SCREEN parameter allows importing of ambulatory procedures into a bill. Only CPT procedures that are either Billable Ambulatory Surgical Codes or nationally or locally active ambulatory procedures may be transferred.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

INTRODUCTION, cont.

Group 3, cont.

The per diem start date is the date that your facility informed Category C patients of the new per diem charges and began per diem billing. This field represents the earliest date for which the hospital or nursing home per diem charge may be billed to a Category C patient. This billing is mandated by Public Law 101-508, which was implemented on November 5, 1990. Please note that per diem billing will not occur if this field is blank.

A default revenue code, diagnosis code, and CPT procedure code can be set to be used on every bill that has prescription refills. The revenue code default will be overridden by the PRESCRIPTION REFILL REV. CODE for an insurance company, if one exists. Only activated revenue codes can be entered.

Set the SUPPRESS MT INS BULLETIN parameter to YES to suppress the bulletin sent when any Means Test charge covered by the patient's health insurance is billed.

Group 4

The first parameter in this group, if set to YES, will allow printing of "001" next to the total charges on the bill. This number is the revenue code for total charges. If the HOLD MT BILLS W/INS parameter is answered YES, automated Category C bills will automatically be placed on hold if the patient has active insurance. The bills may be released to Accounts Receivable after claim disposition from the insurance company. The next parameter allows the user to enter remarks to appear on every printed UB billing form type. The UB-92 Address Col and HCFA 1500 Addr Col parameters determine where the mailing address will begin printing on the billing form. The cancellation remark is the message which will be sent to Fiscal Service every time a bill is cancelled in MAS.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

INTRODUCTION, cont.

Group 4, cont. The next two parameters in this group allow mail groups to be set up so that whenever a bill is cancelled or disapproved, members of these groups are notified via electronic mail. If these groups are not specified, only the billing supervisor, user who cancelled/disapproved, and the initiator of the bill (for disapproval message only) will be notified. The Copay Background Error group is the mail group that will receive mail messages from the IBE filer when an unsuccessful attempt to file is detected. The Category C Billing mail group members will receive messages when Means Test/Category C billing processing errors have been encountered, and when movements and Means Tests for Category C patients have been edited or deleted. The mail groups must have been established through MailMan in order to be entered at these prompts.

Group 5 The agent cashier's mailing symbol, complete address, and telephone number are specified here. The street address will not appear on the screen. All billing payments made to the site should be received at the agent cashier's office.

The default form type is the form most commonly used at your facility (UB-82 or UB-92). All new bills and all follow-up bills will be printed on this form unless the primary insurer has the other UB form defined as their form type. The DEFAULT FORM TYPE parameter helps to control the transition between the UB-82 and the UB-92.

The MCCR System Definition Menu and this option is locked with the IB SUPERVISOR security key.

If necessary, please refer to the Data Supplement at the end of this option documentation for an explanation of the required response for each parameter.

The chart on the following page shows the prompts and steps involved in using this option.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

PROCESS

The following chart shows the prompts and steps involved in using the MCCR Site Parameter Enter/Edit option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	MEDICAL CARE COST RECOVERY PARAMETER ENTER/EDIT ========== [1] Medical Center Name: Federal Tax #: Default BC/BS #: Medicare Number: MAS Service Pointer: Default Division: [2] Bill Signer Name: Title: Billing Supervisor: [3] Multiple Form Types: Initiator Authorize: Use Non-PTF Codes?: Ask Hinq in MCCR?: Use OP CPT screen?: Default ASC Rev. Cd: Xfer Proc to Sched?: Per Diem Start Date: Default RX Rev. Cd: Suppress MT Ins. Bulletin: Default RX Dx Cd: Default RX CPT Cd: [4] '001' for Total?: Hold MT Bills W/Ins: Remark on each bill: UB-92 Address Col: Cancellation Remark: HCFA 1500 Addr Col: Cancelled Mailgroup: Disap. Mailgroup: Copay Mailgroup: Cat C Mailgroup: [5] Agent Cashier: Phone: Default Form Type: Enter 1-5 to EDIT or <^> to QUIT:	.number(s) of the group(s) of items you wish to edit .<?> for HELP Screen .<RET> or up-arrow <^>	2 1 3
2	Selected items are displayed for editing. Enter a <RET> to accept the current value or enter the desired value. A <?> may be entered at most items for an explanation of that data field or you may refer to the Data Supplement at the end of this option documentation for further explanation. After editing, the parameters are redisplayed with the new values.		
3	Return to the menu.		

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

EXAMPLE
The following is an example of what may appear on the screen while using the MCCR Site Parameter Enter/Edit option. User responses are shown in boldface type.

```
Select MCCR System Definition Menu Option:  MCCR Site Parameter Enter/Edit

            MEDICAL CARE COST RECOVERY PARAMETER ENTER/EDIT
================================================================================
[1] Medical Center Name: SAN DIEGO        Federal Tax #     : 13-8887799
    Default BC/BS #    : 1029765384123    Medicare Number   : 12332143
    MAS Service Pointer: MEDICAL ADMIN.   Default Division  : SAN DIEGO

[2] Bill Signer Name   : HARVEY EPSTEIN  Title: CHIEF, MAS
    Billing Supervisor : PATRICIA CAMPANA

[3] Multiple Form Types: YES             Initiator Authorize: YES
    Use Non-PTF Codes? : UNSPECIFIED       Ask Hinq in MCCR?: UNSPECIFIED
    Use OP CPT Screen? : UNSPECIFIED     Default ASC Rev. Cd: 490
    Xfer Proc to Sched?: YES             Per Diem Start Date: NOV  5, 1990
    Default RX Rev. Cd : 257        Suppress MT Ins Bulletin: UNSPECIFIED
    Default RX Dx Cd   : V68.1             Default RX CPT Cd: 99070

[4] '001' for Total?   : YES             Hold MT Bills W/Ins: YES
    Remark on each bill: TEST BILL         UB-92 Address Col: UNSPECIFIED
    Cancellation Remark: TESTING          HCFA 1500 Addr Col: 25
    Cancelled Mailgroup: PTF                Disap. Mailgroup: PTF
    Copay Mailgroup    : IB ERROR            Cat C Mailgroup: IB CAT C

[5] Agent Cashier      : ISC-04
    Phone              : 518-562-4307    Default Form Type  : UB-92
Enter 1-5 to EDIT, or '^' to QUIT:  3

MULTIPLE FORM TYPES: YES// <RET>
CAN INITIATOR AUTHORIZE?: YES// <RET>
CAN CLERK ENTER NON-PTF CODES?: NO
ASK HINQ IN MCCR: YES
USE OP CPT SCREEN?: NO
DEFAULT AMB SURG REV CODE: 490// <RET>
TRANSFER PROCEDURES TO SCHED?: YES// <RET>
PER DIEM START DATE: NOV 5,1991// <RET>
DEFAULT RX REFILL REV CODE: 257// <RET>
SUPPRESS MT INS BULLETIN: NO
DEFAULT RS REFILL DX: V68.1// <RET>
DEFAULT RX FEFILL CPT: 99070// <RET>
```

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

EXAMPLE, cont.

```
            MEDICAL CARE COST RECOVERY PARAMETER ENTER/EDIT
===============================================================================
[1] Medical Center Name: SAN DIEGO        Federal Tax #     : 13-8887799
    Default BC/BS #    : 1029765384123    Medicare Number   : 12332143
    MAS Service Pointer: MEDICAL ADMIN.   Default Division  : SAN DIEGO

[2] Bill Signer Name   : HARVEY EPSTEIN  Title: CHIEF, MAS
    Billing Supervisor : PATRICIA CAMPANA

[3] Multiple Form Types: YES             Initiator Authorize: YES
    Use Non-PTF Codes? : NO                Ask Hinq in MCCR?: YES
    Use OP CPT Screen? : NO              Default ASC Rev. Cd: 490
    Xfer Proc to Sched?: YES              Per Diem Start Date: NOV  5, 1990
    Default RX Rev. Cd : 257        Suppress MT Ins Bulletin: NO
    Default RX Dx Cd   : V68.1               Default RX CPT Cd: 99070

[4] '001' for Total?   : YES             Hold MT Bills W/Ins: YES
    Remark on each bill: TEST BILL         UB-92 Address Col: UNSPECIFIED
    Cancellation Remark: TESTING          HCFA 1500 Addr Col: 25
    Cancelled Mailgroup: PTF                Disap. Mailgroup: PTF
    Copay Mailgroup    : IB ERROR            Cat C Mailgroup: IB CAT C

[5] Agent Cashier      : ISC-04
    Phone              : 518-562-4307    Default Form Type  : UB-92
Enter 1-5 to EDIT, or '^' to QUIT:  <RET>
```

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

DATA SUPPLEMENT

AGENT CASHIER MAIL SYMBOL	Mailing symbol of agent cashier at your facility.
AGENT CASHIER STREET ADDRESS AGENT CASHIER CITY AGENT CASHIER STATE AGENT CASHIER ZIP CODE	Mailing address of agent cashier at your facility.
AGENT CASHIER PHONE NUMBER	Telephone number of agent cashier at your facility.
ASK HINQ IN MCCR	YES or NO - Allow billing clerk to enter a request in the HINQ Suspense file while entering a bill for a patient whose eligibility is not verified.
BILL CANCELLATION MAIL GROUP	Specify the mail group you want notified whenever a third party bill is cancelled.
BILL DISAPPROVED MAIL GROUP	Specify the mail group you want notified whenever a third party bill is disapproved.
BILLING SUPERVISOR NAME	Name of billing supervisor at your facility.
BLUE CROSS/SHIELD PROVIDER #	Main provider number (3 - 13 characters).
CAN CLERK ENTER NON-PTF CODES	YES or NO - Can diagnosis and procedure codes not found in the PTF record be entered into the billing record.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

DATA SUPPLEMENT, cont.

CAN INITIATOR AUTHORIZE	YES or NO - Beginning with Version 1.5 of Integrated Billing, the review step of creating a bill has been eliminated. If this parameter is answered YES and the initiator holds the IB AUTHORIZE key, the initiator of the bill will be allowed to authorize the bill. If this field is answered NO, another user who holds the IB AUTHORIZE key must authorize the bill.
CANCELLATION REMARK FOR FISCAL	Remark (reason for cancellation, 3-75 characters) which will be sent to Fiscal Svc. every time a bill is cancelled in MAS.
CATEGORY C BILLING MAIL GROUP	Members of this mail group will receive messages when Means Test/Category C billing processing errors have been encountered, and when movements and Means Tests for Category C patients have been edited or deleted.
COPAY BACKGROUND ERROR GROUP	This is the mail group that will receive mail messages from the IBE filer when an unsuccessful attempt to file is detected.
DEFAULT AMB SURG REV CODE	When billing BASCs (Billable Ambulatory Surgical Codes), this will be the default revenue code stored in the bill. If this is not appropriate for any particular insurance company, the AMBULATORY SURG. REV. CODE field in the INSURANCE COMPANY file may be used for that particular insurance company entry.
DEFAULT DIVISION	This field will appear as the default answer to the division question when entering Billable Ambulatory Surgeries on a bill.
DEFAULT FORM TYPE	Enter the form type most commonly used at your facility. Choose from UB-82 or UB-92.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

DATA SUPPLEMENT, cont.

DEFAULT RX REFILL CPT	Enter a CPT procedure code that should be printed on every bill that contains RX refills. If entered, this procedure will automatically be added to every bill that has a prescription refill.
DEFAULT RX REFILL DX	Enter a diagnosis code that should be added to every RX refill bill. If entered, this diagnosis will automatically be added to every bill that has a prescription refill.
DEFAULT RX REFILL REV CODE	Enter the revenue code that should be used for RX refills. This default will be over-ridden by the PRESCRIPTION REFILL REV. CODE for an insurance company, if one exists. Only activated revenue codes can be selected.
FEDERAL TAX NUMBER	Enter the federal tax number for your facility in NN-NNNNNNN format.
HCFA 1500 ADDRESS COLUMN	This is the column the mailing address should begin printing on row 1 of the HCFA-1500 form.
HOLD MT BILLS W/INS	If this parameter is answered YES, the automated Category C bills will automatically be placed on hold for patients with active insurance. The bills may be released to Accounts Receivable after claim disposition from the insurance company.
MAS SERVICE POINTER	Medical Administration Service as it is entered in your HOSPITAL SERVICE file.
MEDICARE PROVIDER NUMBER	Provided by Medicare to your facility (1-8 characters). This number will print in Form Locator 7 on the UB-82 form.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

DATA SUPPLEMENT, cont.

MULTIPLE FORM TYPES	YES or NO - Set this field to YES if your facility uses more than one type of health insurance form. The UB forms and the HCFA-1500 are the form types currently available. If this parameter is set to NO or left blank, only UB forms will be allowed.
NAME OF CLAIM FORM SIGNER	Name of person responsible for signing third party billing form.
PER DIEM START DATE	This is the date that your facility informed Category C patients of the new per diem charges and began per diem billing. Per diem billing will not occur if this field is left blank.
PRINT '001' FOR TOTAL CHARGES	YES or NO - Print '001' (revenue code for total charges) next to total charges on third party bill.
REMARKS TO APPEAR ON EACH FORM	Facility specific remarks to print on every UB type bill.
SUPPRESS MT INS BULLETIN	YES or NO - Set this parameter to YES to suppress the bulletin sent when any Means Test charge covered by the patient's health insurance is billed.
TITLE OF CLAIM FORM SIGNER	Title of person responsible for signing third party billing form.
TRANSFER PROCEDURES TO SCHED	YES or NO - If this parameter is answered YES, as CPT procedures that are also ambulatory procedures are entered in a bill, the user will be prompted to indicate whether they should also be transferred to the SCHEDULING VISITS file.

MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

DATA SUPPLEMENT, cont.

UB-92 ADDRESS COLUMN	This is the column on which the mailing address should begin printing on the UB-92.
USE OP CPT SCREEN	YES or NO - Allow Current Procedural Terminology Codes Screen to appear when editing procedure codes on Screen 5. The screen will list CPT codes for the dates associated with the bill.

MCCR System Definition Menu
Update Rate Type File

INTRODUCTION

The Update Rate Type File option is used to add new entries to the RATE TYPE file (#399.3) or to edit existing entries. The rate type identifies the kind of bill and determines how charges will be calculated. Examples of rate types include Means Test/Cat C., reimbursable insurance, worker's compensation, and sharing agreement. A billing record cannot be established with a rate type that is inactive.

The abbreviated name entered through this option will appear as the rate type on all outputs containing the bill type. The entry made at the BILL NAME prompt of this option will appear in the Remarks Section of the UB form types. This prompt provides the opportunity to decide how the rate type name will appear on the bill (i.e., CV for crime victim).

If YES is entered at the "Is this a third party bill?" prompt, the ASSIGNMENT OF BENEFITS field will auto-matically be set to YES when entering billing data on bills with this rate type.

The REIMBURSABLE INSURANCE?: field should be answered YES if the rate type is a reimbursable insurance. NO should be entered for all other rate types.

The statement, "The undersigned certifies that treatment rendered is not for a service connected disability", will be printed on bills for the selected rate type if the NSC STATEMENT ON UB BILLS field is answered YES. This should be answered YES for all rate types where the bill can only be for NSC care.

The accounts receivable category must be specified through this option in order to pass the correct rate type to Fiscal Service when entering billing information. It is used to match the corresponding entries in the MAS and Fiscal Service RATE TYPE files. This entry will also determine "Who's Responsible" (i.e., the expected debtor for this rate type).

You must hold the IB SUPERVISOR security key to access this option.

The chart beginning on the following page shows the prompts and steps involved in using the Update Rate Type File option.

MCCR System Definition Menu
Update Rate Type File

PROCESS
The following chart shows the prompts and steps involved in using the Update Rate Type File option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select RATE TYPE NAME:	.new rate type	2
		.existing rate type	4
		.<RET> or up-arrow <^>	11
2	ARE YOU ADDING '{name}' AS A NEW RATE TYPE (THE nTH)?	.YES	3
		.NO	1
	The next number in the internal numbering sequence will appear as the default.		
3	RATE TYPE NUMBER: {number}//	.<RET> to accept default	4
		.other number	4
	The following prompt will now appear: RATE TYPE WHO'S RESPONSIBLE. Enter a <RET> at this prompt. The entry will automatically be determined by the entry at Step 10, ACCOUNTS RECEIVABLE CATEGORY.		
4	NAME: {entry at Step 1}//	.<RET> to accept default	6
		.correct rate type	6
		.at-sign (@) to delete entire entry	5
5	SURE YOU WANT TO DELETE THE ENTIRE '{name}' RATE TYPE?	.YES	11
		.NO	4

MCCR System Definition Menu
Update Rate Type File

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	The prompts at Steps 6-10 will have a default value if the user is editing an existing rate type, and an entry has been made for that field. A <RET> may be entered to accept the default value or a new value may be entered. In the following Steps, a new authorization is assumed and no default value is shown.		
6	BILL NAME:	.name that will appear on the bill (1-30 characters in length)	7
7	ABBREVIATION:	.abbreviated version of rate type name (2-8 characters)	8
8	IS THIS A THIRD PARTY BILL?:	.1 or YES if this rate type constitutes a third party bill	9
		.0 or NO if this rate type does not constitute a third party bill	9
9	REIMBURSABLE INSURANCE?:	.1 or YES if this is a reimbursable insurance rate type	10
		.0 or NO for all other rate types	10
	If this prompt is answered YES, the statement, "The undersigned certifies that treatment rendered is not for a service connected disability" will print on bills of this rate type.		
10	NSC STATEMENT ON UB82?:	.1 or YES for all rate types where the bill can only be for NSC care	11
		.0 or NO for all other rate types	11

MCCR System Definition Menu
Update Rate Type File

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
11	INACTIVE:	.1 or YES if this rate type is to be INACTIVE	12
		.0 or NO if this rate type is to be ACTIVE	12
12	ACCOUNTS RECEIVABLE CATEGORY:	.accounts receivable category abbreviation	13
		.<?> for category list	12
13	Return to the menu.		

MCCR System Definition Menu
Update Rate Type File

EXAMPLE
The following is an example of what might appear on the screen while using the Update Rate Type File option. User responses are shown in boldface type.

```
Select RATE TYPE NAME:  SHARING AGREEMENT
   ARE YOU ADDING 'SHARING AGREEMENT' AS A NEW RATE TYPE (THE 11th)?  Y
(YES)
   RATE TYPE NUMBER: 10//  <RET>
   RATE TYPE WHO'S RESPONSIBLE:  <RET>
NAME: SHARING AGREEMENT//  <RET>
BILL NAME:  SHARING AGREEMENT
ABBREVIATION:  SH AG
IS THIS A THIRD PARTY BILL?  YES
REIMBURSABLE INSURANCE?:  NO
NSC STATEMENT ON UB82?:  NO
INACTIVE:  NO
ACCOUNTS RECEIVABLE CATEGORY: SA  SHARING AGREEMENTS  SA
```

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

A new set of parameters has been added to the IB Site Parameters screen. These parameters are used to configure the Tricare Pharmacy billing interface, and must be set prior to starting the background filer. The new parameters are described in the Introduction.

Parameter Group	Security Key Required
IB Site Parameters	IB SUPERVISOR
Claims Tracking Parameters	IB CLAIMS SUPERVISOR
Third Party Auto Billing Parameters	IB SUPERVISOR

Introduction

This option consolidates parameters from the Enter/Edit IB Site Parameters, MCCR Site Parameter Enter/Edit, Claims Tracking Parameter Edit, and Enter/Edit Automated Billing Parameters options. The initial screen lists three parameter groups.

Following is a list of the screens, the actions they provide, and a brief description of each action. Actions shown in *italics* access other screens.

MCCR Site Parameters Screen

IB Site Parameters - accesses the IB Site Parameter screen which displays general Integrated Billing site parameters.

Claims Tracking Parameters - accesses the Claims Tracking Parameters screen which displays parameters specific to the set-up and control of Claims Tracking functions.

Third Party Auto Billing Parameters - accesses the Automated Billing Parameters screen which displays the control parameters for the Third Party Automated Biller.

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Introduction, cont.

IB Site Parameters Screen

Descriptions for most of the parameters included on this screen can be found in the Enter/Edit IB Site Parameters and MCCR Site Parameter Enter/Edit option documentation. Following is a description of the six parameters (group 12) used to configure the Tricare Pharmacy billing interface that are user set. The other seven parameters in this group that appear on the right hand side of the screen are set by the system.

Rx Billing Port - This is the logical port that is opened to establish a TCP/IP connection with the RNA package to submit Pharmacy claims. This is normally a number between 2000 and 10000. The number that is selected is programmed into the RNA package, as this is the port that the RNA package constantly polls for input from V*IST*A. The Billing port must be entered to start the billing engine.

AWP Update Port - This is the logical port that is opened to establish a TCP/IP connection with the RNA package to receive AWP updates. This is normally a number between 2000 and 10000. This number is also programmed into the RNA package, as it is the port through which the RNA package transmits the AWP updates. This port number must be different from the Billing port number, or the background job to receive AWP updates will not be queued to run.

TCP/IP Address - This is the TCP/IP address used to reach the RNA package. This address is usually determined by the facility systems manager and supplied to RNA on the Plan Installation Worksheet. This address must be entered to start the billing engine.

Task UCI,VOL - This is UCI and Volume set on which the queued background jobs should run. If this field has no value (i.e., for Alpha sites), the jobs will be queued to run on the current UCI and Volume.

AWP Charge Set This is the Charge Set within the Charge Master which was used to load the AWP. The interface must know which Charge Set should be used to extract a unit price for a specific NDC number (drug). A valid Charge Set must be entered to start the billing engine.

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Introduction, cont.

Prescriber ID - This is the DEA number assigned to your facility, which you should determine prior to the installation of the RNA package. This number must be submitted with the Pharmacy Billing transaction. The number must be entered to start the billing engine.

Edit Set - This action allows you to view/edit the fields included in the 12 sets displayed.

Claims Tracking Parameters Screen
Descriptions of the parameters included on this screen can be found in the Claims Tracking Parameter Edit option documentation.

Tracking - allows you to edit the data displayed under the Tracking Parameters heading. These parameters control which episodes of care are added to Claims Tracking.

Random Sample - allows you to edit the data displayed under the Random Sample Parameters heading. These parameters control the selection of random samples.

General - allows you to edit the data displayed under the General Parameters heading.

Edit All - allows you to edit all data displayed on the Claims Tracking Parameters screen.

Automated Billing Parameters Screen
Descriptions of the parameters included on this screen can be found in the Enter/Edit Automated Billing Parameters option documentation.

General - allows you to edit the data displayed under the General Parameters heading.

Inpatient - allows you to edit the data displayed under the Inpatient Admission heading. These parameters control if and when inpatient episodes of care are processed by the Third Party automated biller.

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Introduction, cont.

Outpatient - allows you to edit the data displayed under Outpatient Visit the heading. These parameters control if and when outpatient visits are processed by the Third Party automated biller.

Prescription - allows you to edit the data displayed under the Prescription Refill heading. These parameters control if and when prescription refills are processed by the Third Party automated biller.

Example 1 - MCCR Site Parameters Screen (Main Screen)

```
MCCR Site Parameters          May 13, 1996 10:45:52          Page:    1 of    1
Display/Edit MCCR Site Parameters.
Only authorized persons may edit this data.

 IB Site Parameters                      Claims Tracking Parameters
    Facility Definition                     General Parameters
    Mail Groups                             Tracking Parameters
    Patient Billing                         Random Sampling
    Third Party Billing

 Third Party Auto Billing Parameters
    General Parameters
    Inpatient Admission
    Outpatient Visit
    Prescription Refill

          Enter ?? for more actions
IB  Site Parameter        CT  Claims Tracking       AB  Automated Billing
                                                    EX  Exit Action
Select Action: Quit// IB   Site Parameter
```

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Example 2 - IB Site Parameters Screen

```
IB Site Parameters           May 13, 1996 10:49:28          Page:    1 of    3
Only authorized persons may edit this data.

[1] Copay Background Error Mg: IB ERROR
    Copay Exemption Mailgroup: IB ERROR
    Use Alerts for Exemption : YES

[2] Per Diem Start Date      : 01/01/00
    Hold MT Bills w/Ins      : YES
    Suppress MT Ins Bulletin : NO
    Cat C Mailgroup          : IB CAT C

[3] Disapproval Mailgroup    : PTF
    Cancellation Mailgroup   : PTF
    Cancellation Remark      : TESTING CANCELLATION IN MAS

[4] New Insurance Mailgroup  : IB NEW INSURANCE
    Unbilled Mailgroup       : IB UNBILLED AMOUNTS
    Auto Print Unbilled List : NO

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
Select Action: Next Screen//
```


```
IB Site Parameters           May 13, 1996 10:49:28          Page:    1 of    3
Only authorized persons may edit this data.

[1] Copay Background Error Mg: IB ERROR
    Copay Exemption Mailgroup: IB ERROR
    Use Alerts for Exemption : YES

[2] Per Diem Start Date      : 01/01/00
    Hold MT Bills w/Ins      : YES
    Suppress MT Ins Bulletin : NO
    Cat C Mailgroup          : IB CAT C

[3] Disapproval Mailgroup    : PTF
    Cancellation Mailgroup   : PTF
    Cancellation Remark      : TESTING CANCELLATION IN MAS

[4] New Insurance Mailgroup  : IB NEW INSURANCE
    Unbilled Mailgroup       : IB UNBILLED AMOUNTS
    Auto Print Unbilled List : NO

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
Select Action: Next Screen//
```

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Example 3 - Claims Tracking Parameters Screen

```
Claims Tracking Parameters   May 13, 1996 10:52:27          Page:    1 of    1
Only authorized persons may edit this data.

          Tracking Parameters                  Random Sample Parameters
     Track Inpatient: ALL PATIENTS              Medicine Sample: 5
    Track Outpatient: INSURED ONLY          Medicine Admissions: 5
            Track Rx: ALL PATIENTS               Surgery Sample: 5
   Track Prosthetics: INSURED ONLY           Surgery Admissions: 5
  Reports Can Add CT: YES                           Psych Sample: 0
                                                Psych Admissions: 5

          General Parameters
 Initialization Date: 09/01/94
 Use Admission Sheet: YES
       Header Line 1: ALBANY VAMC
       Header Line 2: 113 HOLLAND AVE
       Header Line 3: ALBANY, NY 12305

          Enter ?? for more actions
TP  Tracking                RS  Random Sample          GP  General
EA  Edit All                                           EX  Exit Action
Select Action: Quit//
```

Example 4 - Automated Billing Parameters Screen

```
Automated Billing Parameters  May 13, 1996 10:54:11         Page:    1 of    1
Only authorized persons may edit this data.

          GENERAL PARAMETERS                   INPATIENT ADMISSION
 Auto Biller Frequency: 1                   Automate Billing: YES
   Date Last Completed: 04/30/96               Billing Cycle: 20
      Inpatient Status: Closed                    Days Delay: 1

          OUTPATIENT VISIT                     PRESCRIPTION REFILL
      Automate Billing: YES                 Automate Billing: YES
         Billing Cycle: 10                     Billing Cycle: 3
            Days Delay: 1                         Days Delay: 1

          Enter ?? for more actions
GP  General                 IP  Inpatient              OP  Outpatient
RX  Prescription                                       EX  Exit A ction
Select Action: Quit//
```

Unbilled Amounts Menu
Re-Generate Average Bill Amounts

INTRODUCTION This option is used to rebuild and store the monthly and yearly counts and dollar amounts of inpatient and outpatient bills for a single month. This data will overwrite any previously stored data.

If a past month is selected, the monthly totals for that month are recomputed and the subsequent yearly totals are updated. Previous months' data is also calculated, when required, in order to obtain yearly values. This information is used to compute the average bill amount for the Unbilled Amounts Report.

Once the average bill amounts are calculated, the Unbilled Amounts Report is automatically generated , via electronic mail, for the selected month. This mail message is sent to the mail group specified in the UNBILLED MAIL GROUP field of the IB SITE PARAMETERS file.

Due to the brevity of this option, no process chart is provided.

Unbilled Amounts Menu
Re-Generate Average Bill Amounts

EXAMPLE
The following is an example of what might appear on your screen while using this option. User responses are shown in boldface type.

```
Re-Generate Average Bill Amounts for Unbilled Amounts Report


For Month of : 1/95  (JAN 1995)

This will automatically be tasked to run and needs no device.

A mail Message will be sent when the process completes, use the option
View Unbilled Amounts to see cumulative totals.


Requested Start Time: NOW// <RET> (MAR 20, 1995@10:23:24)
```

Unbilled Amounts Menu
Re-Generate Unbilled Amounts Report

INTRODUCTION This option is used to regenerate the Unbilled Amounts Report for a single month. This recomputes the unbilled care for the month and updates the unbilled amounts. To simply view previously computed data, please use the View Unbilled Amounts option.

Due to the brevity of this option, no process chart is provided.

Unbilled Amounts Menu
Re-Generate Unbilled Amounts Report

EXAMPLE

The following is an example of what might appear on your screen while using this option followed by a sample output. User responses are shown in boldface type.

```
Re-Generate Unbilled Amounts Report


Print Patient Listing? NO// Y  YES

For Month of : 1/95  (JAN 1995)

You will need a 132 column printer for this report!

DEVICE: HOME// A138-16/6/UP  KYOCERA PRINTER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)



Unbilled Inpatient Patient Listing for: 01/95                    Page 1  Mar 20, 1995@10:40:09
                                                  Claims
Patient Name      Pt. ID.      Date of Care       Tracking ID  Eligibility       Insurance Companies
-------------------------------------------------------------------------------------------------
ABBOTT,JOHN A.    411-01-0101  Nov 27, 1993@11:22  500382       NON-SERVICE CONN  GHI,BIG TREE I
ACKERLEY,DENNIS   078-46-0348  Mar 29, 1994@13:00  500410       SC, LESS THAN 50  BLUE CROSS
ADRIANCE,KENNETH  108-10-9937  May 06, 1994@08:00  500468       NON-SERVICE CONN  BLUE CROSS
APPLE,CHARLES     135-98-4444  Mar 24, 1994@07:34  500399       HUMANITARIAN EME  HEALTH INS
BARRY,KEVIN       023-44-3256  Feb 01, 1994@14:25  500434       NON-SERVICE CONN  STRAIT INS
BOOK,JOHN         233-45-6711  Sep 01, 1993@17:07  50020        SC, 50% TO 100%   GHI
BORDEAU,DOUGLAS   201-09-0842  May 01, 1993@11:00  50012        NON-SERVICE CONN  BLUE CROSS
CHARLES,SEAN      445-54-4554  Feb 07, 1994@14:42  500365       NON-SERVICE CONN  AETNA,BLUE CROSS
```

Unbilled Amounts Menu
Send Test Unbilled Amounts Bulletin

INTRODUCTION This option allows you to send a test mail message to the mail group receiving the unbilled amounts messages. This option should be used prior to reporting problems to assist sites in determining whether the mail groups are set up correctly. The mail group you wish to receive the message should be specified in the UNBILLED MAIL GROUP (6.25) field in the IB SITE PARAMETERS file (350.9).

Due to the brevity of this option, no process chart is provided.

Unbilled Amounts Menu
Send Test Unbilled Amounts Bulletin

EXAMPLE
The following is an example of what might appear on your screen while using this option followed by a sample mail message.

```
Message being sent to Mail Group IB UNBILLED AMOUNTS          .
Message sent!


Subj: UNBILLED AMOUNTS Report for Oct. 2099  [#121659] 06 Jul 95 09:38
  20 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1  **NEW**
-------------------------------------------------------------------------------

The Unbilled Amounts for Oct. 2099 has successfully completed for
ALBANY (633).

Test Data Only, Test Data Only, Test Data Only
Inpatient Care
   Number of Unbilled Inpt Cases :        1,111
   Average Inpt. Bill Amount     :       $9,999.99
   Total Unbilled Inpt Care      :  $11,109,988.89

Outpatient Care:
   Number of Unbilled Opt Cases  :       33,333
   Average Opt. Bill Amount      :         $222.22
   Total Unbilled Opt. Care      :   $7,407,259.26

Total Unbilled Amount all care   :  $18,517,248.15
Enter RETURN to continue or '^' to exit: <RET>


Subj: UNBILLED AMOUNTS Report for Oct. 2099  [#121659]    Page 2
-------------------------------------------------------------------------------

Note:  Average bill Amount is based on Bills Authorized during the 12
       months preceding the month of this report.
Note:  Number of cases is insured cases in Claims Tracking that are
       not billed (or bill not authorized) but appear to be billable.


Select MESSAGE Action: IGNORE (in IN basket)//
```

Unbilled Amounts Menu
View Unbilled Amounts

INTRODUCTION This option is used to view previously computed unbilled amounts without having to re-compile the data.

Due to the brevity of this option, no process chart is provided.

Unbilled Amounts Menu
View Unbilled Amounts

EXAMPLE
The following is an example of what might appear on your screen while using this option followed by a sample output. User responses are shown in boldface type.

```
View unbilled amounts

DEVICE: HOME// <RET>  Decnet    RIGHT MARGIN: 80// <RET>

Unbilled Amounts Report                          Page 1  Mar 22, 1995@09:09:28
------------------------------------------------------------------------------

          Inpatient Care: 02/95
   Number of Unbilled Inpt. Cases:           54
        Average Inpt. Bill Amount:     $5,552.22
         Total Inpatient Unbilled:   $299,819.88

          Outpatient Care: 02/95
   Number of Unbilled Opt.  Cases:          192
         Average Opt. Bill Amount:       $179.00
        Total Outpatient Unbilled:    $34,368.00

          Inpatient Care: 01/95
   Number of Unbilled Inpt. Cases:           16
        Average Inpt. Bill Amount:     $5,832.75
         Total Inpatient Unbilled:    $93,324.00

          Outpatient Care: 01/95
   Number of Unbilled Opt.  Cases:            0
         Average Opt. Bill Amount:       $178.93
        Total Outpatient Unbilled:         $0.00
```

Third Party Joint Inquiry

INTRODUCTION

This option provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care. This information is presented in List Manager Screens.

Because the same actions are available on most screens, and most screens can be accessed from any other screen; these "Common Actions" are listed first and are not repeated under each screen description. Only actions specific to a screen are included with that screen description.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. EXIT returns you to the menu. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Actions shown in italics access other screens.

Common Actions

BC Bill Charges - Accesses the Bill Charges screen.

DX Bill Diagnoses - Accesses the Bill Diagnoses screen.

PR Bill Procedures - Accesses the Bill Procedures screen.

CI Go to Claim Screen - Returns you to the Claim Information screen. Available on all screens that may be opened from the Claim Information screen.

AR Account Profile - Accesses the AR Account Profile screen.

CM Comment History - Accesses the AR Comment History screen.

IR Insurance Reviews - Accesses the Insurance Reviews/ Contacts screen.

Third Party Joint Inquiry

INTRODUCTION cont.

HS Health Summary - Displays a Health Summary report. The information displayed on the Health Summary is site specified through the MCCR Site Parameter Display/Edit option.

AL Go to Active List - Returns you to the Third Party Active Bills screen if that screen was accessed upon entering this option; otherwise, this action returns you to the menu.

VI Insurance Company - Accesses the Insurance Company screen.

VP Policy - Accesses the Patient Policy Information screen.

AB Annual Benefits - Accesses the Annual Benefits screen.

EL Patient Eligibility - Accesses the Patient Eligibility screen.

EX Exit Action - Exits the option.

Third Party Active Bills Screen

This is the first screen displayed if you enter a patient name at the first prompt of this option. It lists all active third party bills for the specified patient in order of date created. All bills created in the Integrated Billing Third Party Billing module can be found on this screen or the Inactive Bills screen.

Actions

IL Inactive Bills - Accesses the Inactive Bills screen.

PI Patient Insurance - Accesses the Patient Insurance screen.

CP Change Patient - Allows you to choose another patient and re-displays the Third Party Active Bills screen for that patient.

Third Party Joint Inquiry

INTRODUCTION cont.

Inactive Bills Screen

This screen lists inactive bills for a specified patient. All bills created in the Integrated Billing Third Party Billing module are found on this screen or the Third Party Active Bills screen. Bills are displayed beginning with most recent "statement from" date.

Actions

CD Change Dates - Allows you to change the bills listed by changing the most recent "statement from" date to be displayed.

Patient Insurance Screen

This screen displays the list of insurance policies for a patient. It is based on the Patient Insurance Management screen of the Patient Insurance Info View/Edit option. It is only available from the Third Party Active Bills screen.

Claim Information Screen

This screen contains bill data and status information to provide an overall status of the bill. This is the primary claim screen for the inquiry, and many actions are provided to expand on the details of the claim.

If a policy has been updated but the bill has not, those changes are not reflected on this screen. Updated or current insurance information may be viewed using the three insurance screens.

Actions

CB Change Bill - Allows you to change the bill being displayed. If you entered a patient name at the first prompt of this option, only bills for that patient may be selected. If you entered a bill number at the first prompt, any bill may be selected.

Third Party Joint Inquiry

INTRODUCTION cont.

Bill Charges Screen
This screen displays a bill's charge information as it would print on the bill. For UB-92 bills, this closely corresponds to Form Locators 42-49; therefore, any prosthetic items, Rx refills, or additional diagnoses and procedures are included. For HCFA 1500 bills, this closely corresponds to Block 24.

Bill Diagnosis Screen
This screen displays all diagnoses assigned to the bill, in the order they are printed on the bill.

Bill Procedures Screen
This screen lists all procedures assigned to a bill, in the order they are printed on the bill.

AR Account Profile Screen
This screen provides the financial history of a claim's account. This includes the current status of the bill in both IB and AR, as well as the payment or transaction history of the bill from Accounts Receivable. This screen is loosely based on the Profile of Accounts Receivable option.

Actions

VT Transaction Profile - Accesses the AR Transaction Profile screen for a selected transaction.

AR Transaction Profile Screen
This screen displays detailed account transaction information for individual claim transactions. It is is loosely based on the Accounts Receivable Transaction Profile option.

Third Party Joint Inquiry

INTRODUCTION cont.

AR Comment History Screen

This screen displays AR comments for the claim's account.

Actions

AD Add AR Comment - Allows you to add an AR Transaction Comment to the bill being displayed. Comment transactions may not be added to a bill that has not been authorized in IB.

Insurance Reviews/Contacts Screen

This screen displays all insurance reviews and contacts for the episodes of care on a bill. It is based on the Insurance Reviews/Contacts screen of the Claims Tracking Insurance Review Edit option. The primary difference between the two screens is that this screen consolidates all contacts for each episode being billed on a claim, while the Claims Tracking screen displays the contacts for a single episode of care.

Actions

VR Reviews/Appeals - Displays expanded information on a selected insurance contact. The screen accessed by this action will depend on the type of contact selected. If the contact is an appeal or denial, the Expanded Appeals/Denials screen is opened; otherwise, the Expanded Insurance Reviews screen is opened.

Expanded Appeals/Denials Screen

This screen displays expanded information on insurance appeals and denials listed on the Insurance Review/Contacts screen. This screen is based on the Expanded Appeals/Denials screen of the Claims Tracking Appeal/Denial Edit option.

Expanded Insurance Reviews Screen

This screen displays expanded information on insurance reviews listed on the Insurance Reviews/Contacts screen. This screen is based on the Expanded Insurance Reviews screen of the Claims Tracking Insurance Review Edit option.

Third Party Joint Inquiry

INTRODUCTION cont.

Insurance Company Screen

This screen displays extended information on an Insurance Company. It is based on the Insurance Company Editor screen of the Insurance Company Entry/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen displays only information related to the insurance carriers assigned to that bill.

Patient Policy Information Screen

This screen displays extended information on insurance policies. It is based on the Patient Policy Information screen of the Patient Insurance Info View/Edit option. This screen may be entered from either the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen will only display information related to the insurance policies assigned to the bill.

Annual Benefits Screen

This screen displays extended information on the annual benefits of insurance policies. It is based on the Annual Benefits Editor screen of the Patient Insurance Info View/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill has been chosen, this screen displays information related to the insurance policies assigned to that bill.

Third Party Joint Inquiry

INTRODUCTION cont.

Patient Eligibility Screen

This screen displays the current information on the patient's eligibility for care and service connection status. It is loosely based on the Eligibility Inquiry for Patient Billing option. This screen is available from the Third Party Active Bills screen and the bill specific screens.

If this screen is accessed from one of the bill specific screens, such as the Claim Information screen, the standard list of bill screen actions will be available from this screen.

If this screen is accessed from the Patient Insurance screen, no other screens are available as actions from this screen; and you must return to a previous screen to access other screens.

Due to the nature of this option, no process chart is provided.

Third Party Joint Inquiry

EXAMPLE

The following examples show the various screens available through this option.

```
Third Party Active Bills          May 31, 1995 @10:07:11                    Page 1 of 1
JONES,ANDREW     A9281                                                          NSC
Bill #        From       To         Type   Stat Rate        Insurer   Orig Amt Curr Amt
1  L10263     04/20/92   04/20/92   OP     BI   REIM INS      HEALTH       0.00     0.00
2  L10270     04/20/92   04/24/92   OP     PC   REIM INS      HEALTH     698.30   698.30
3  N10072 *   11/16/93   11/17/93   OP     N    REIM INS    + HEALTH     199.00   199.00
4  N10094     02/16/94   02/16/94   OP     PC   REIM INS    + HEALTH     196.00   196.00
5  N10123 *   03/01/94   03/15/94   OP     BI   REIM INS    + HEALTH       0.00     0.00
6  N10150 *   03/14/94   03/15/94   OP     BI   REIM INS    + AETNA        0.00     0.00
7  N10173 *   03/02/94   03/03/94   OP     BI   REIM INS      AETNA        0.00     0.00
8  N10174 *   03/06/94   03/07/94   OP     N    REIM INS      AETNA      356.00   356.00
9  N10222     05/01/94   05/31/94   IP-F   BI   REIM INS      HEALTH       0.00     0.00
10 N10236     06/01/94   06/05/94   IP-L   BI   REIM INS      HEALTH       0.00     0.00
11 N10273 *   03/03/94   03/31/94   IP-F   A    REIM INS    + HEALTH   11221.00   856.45
12 N10275     08/30/94   09/30/94   IP     BI   REIM INS      AETNA        0.00     0.00
+          | * Cat C Charges on Hold | + 2nd/3rd Carrier |
CI  Claim Information     IL  Inactive Bills        PI  Patient Insurance
CP  Change Patient        HS  Health Summary        EL  Patient Eligibility
Select Action: Next Screen//
```

```
Inactive Bills                 May 17, 1996 13:30:26              Page:    1 of    2
JONES,ANDREW     A9281                                  ** All Inactive Bills **  (9)
Bill #        From       To         Type   Stat Rate       Insurer  Orig Amt   Curr Amt
1  N10397     06/01/94   06/05/94   IL-L   CC   REIM INS   + AETNA    935.00       0.00
2  N10198     06/01/94   06/05/94   IP-L   CB   REIM INS   + HEALTH     0.00       0.00
3  N10212     05/07/94   05/12/94   IP-C   CB   REIM INS     HEALTH     0.00       0.00
4  N10148 *   03/02/94   03/03/94   OP     CB   REIM INS                0.00       0.00
5  N10162 *   03/02/94   03/03/94   OP     CB   REIM INS                0.00       0.00
6  N10095     02/16/94   02/16/94   OP     CB   REIM INS                0.00       0.00
7  L10260     04/14/92   04/20/92   OP-F   CB   REIM INS     AETNA   1026.02    1026.02
8  L00389     02/08/90   02/08/90   OP     CC   REIM INS     BC/BS     26.00       0.00
9  00036A     02/07/90   02/07/90   OP     CC   REIM INS     BC/BS     26.00       0.00
+          |* Cat C Charges on Hold |+ 2nd/3rd Carrier |
CI  Claim Information     AL  Go to Active List     CD  Change Dates
                                                    EX  Exit Action
Select Action: Next Screen//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Claim Information              May 17, 1996 13:44:58          Page:    1 of    2
N10072   JONES,ANDREW  A9281            DOB: 5/22/50   Subsc ID: 9849333

      Insurance Demographics                    Subscriber Demographics
  Carrier Name:  HEALTH INS LIMITED          Group Number:  GN 48923222
 Claim Address:  789 3RD STREET                Group Name:
                 ALBANY, NY 44438           Subscriber ID:  9849333
   Claim Phone:  333-444-5676                     Employer:  Snow Movers
                                            Insured's Name:  JONES,ANDREW
                                              Relationship:  PATIENT

                              Claim Information
     Bill Type:  OUTPATIENT                 Service Dates:  11/16/93 - 11/17/93
    Time Frame:  ADMIT THRU DISCHARGE CLAIM Date Entered:  12/23/93
     Rate Type:  REIMBURSABLE INS             Orig Claim:  199.00
     AR Status:  NEW BILL                   Balance Due:  199.00
     Secondary:  AETNA

       Entered:  12/23/93  by   Gray,John
    Authorized:  01/04/94  by   Smith,Jane
 First Printed:  01/04/94  by   Smith,Jane
  Last Printed:  04/01/94  by   Brown,Deb
+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CB  Change Bill           HS  Health Summary         EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Next Screen//
```

```
Patient Insurance              May 31, 1995 @10:07:11         Page 1 of   1
Insurance Management for Patient: JONES,ANDREW     A9281
  Insurance Co.    Type of Policy  Group        Holder   Effect.     Expires
1 HEALTH INS LTD                  GN 48923222  SELF     01/01/87
2 AETNA            MAJOR MEDICAL  AE 76899354  SPOUSE   10/1/90     19/30/95
3 PRUDENTIAL       INDEMNITY      T109         OTHER    10/1/94     01/01/95
4 BC/BS            MAJOR MEDICAL  GN 392043    SELF     01/01/90    12/31/92


VI  Insurance Company          VP Policy          AB  Annual Benefits
AL  Go to Active List                             EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10072  JONES,ANDREW     A9281  DOB: 5/22/50              Subsc ID: 9849333
11/16/93 - 11/17/93        ADMIT THRU DISCHARGE          Orig Amt:    199.00
-------------------------------------------------------------------------------

      OUTPATIENT VISIT
500   OUTPATIENT SVS          178.00         1                 178.00
      PRESCRIPTION
257   DRGS/NONSCRPT            21.00         1                  21.00

001   TOTAL CHARGE                                             199.00

      OP VISIT DATE(S) BILLED:          NOV 16, 1993

      PRESCRIPTION REFILLS:
      30948          NOV 17, 1993       ABBOCATH-T 18G 1.25 IN
                                        QTY: 20 for 10 days supply

Bill Remark:  This is a demonstration bill created for Joint Billing Inquiry.

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10273  JONES,ANDREW     A9281  DOB: 5/22/50                Subsc ID:  9849333
03/02/94 - 03/31/94        INTERIM - FIRST CLAIM           Orig Amt: 11221.00

-------------------------------------------------------------------------------

30 DAYS INPATIENT CARE
      INTERMEDIATE CARE
101   ALL INCL R&B          246.00          30            7380.00
240   ALL INCL ANCIL         48.00          30            1440.00
960   PRO FEE                49.00          30            1470.00
274   PROSTH/ORTH DEV       931.00          1              931.00

001   TOTAL CHARGE                                       11221.00

      PROSTHETIC ITEMS:
      Sep 18, 1994  WHEELCHAIR
      Sep 21, 1994  CANE-ALL OTHER

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit A ction
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Bill Diagnosis                 May 17, 1996 14:07:56         Page:    1 of    1
N10072   JONES,ANDREW  A9281           DOB: 5/22/50      Subsc ID: 9849333
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00
-------------------------------------------------------------------------------

      1)  490.     BRONCHITIS NOS
      2)  030.1    TUBERCULOID LEPROSY
      3)  101.     VINCENT'S ANGINA
      4)  330.1    CEREBRAL LIPIDOSES
      5)  461.0    AC MAXILLARY SINUSITIS
      6)  310.0    FRONTAL LOBE SYNDROME
      7)  200.01   RETICULOSARCOMA HEAD

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Procedures                May 17, 1996 14:12:58         Page:    1 of    1
N10072   JONES,ANDREW  A9281           DOB: 5/22/50      Subsc ID: 9849333
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00
-------------------------------------------------------------------------------

 11000   SURGICAL CLEANSING OF SKIN      11/16/93
 11001   ADDITIONAL CLEANSING OF SKIN    11/16/93
 12001   REPAIR SUPERFICIAL WOUND(S)     11/16/93

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
BC  Bill Charges          AR  Account Profile       VI  Insuranc e Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
AR Account Profile              May 31, 1995 @10:07:11        Page:    1 of    1
N10273   JONES,ANDREW     A9281           DOB: 5/22/50   Subsc ID:  9849333
AR Status: ACTIVE         Orig Amt:    11221.00       Balance Due:  856.45

             04/01/94     IB Status:  Printed  (Last)      11221.00   11221.00
1   1578     05/07/94     PAYMENT (IN PART)                 7856.21    3364.79
2   1598     07/07/94     PAYMENT (IN PART)                 2508.34     856.45
3   1601     07/08/94     COMMENT                              0.00     856.45

    Total Collected:   10364.55
    Percent Collected:    92.37%
          Enter ?? for more actions
BC  Bill Charges          VT  Transaction Profile   VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Transaction Profile          May 31, 1995 @10:07:11              Page 1 of 1
N10273   JONES,ANDREW     A9281  DOB: 5/22/50            Subsc ID:  9849333
AR Status:  ACTIVE              Orig Amt:    11221.00   Balance Due:  856.45

      TRANS. NO:  1578              TRANS. TYPE:  PAYMENT (IN PART)
    TRANS. DATE:  05/07/94          DATE POSTED:  05/10/94    (ARH)
  TRANS. AMOUNT:  7856.21             RECEIPT #:  D2982398

                                      BALANCE    COLLECTED
                                 ------------- ---------------
                  PRINCIPLE:          3364.79      7856.21
                  INTEREST:              0.00         0.00
                  ADMINISTRATIVE:        0.00         0.00
                  MARSHALL FEE:          0.00         0.00
                  COURT COST:            0.00         0.00
                                     --------    ---------
                  TOTAL:              3364.79      7856.21

       FY:  94            PR AMT: 3364.79           FY TR AMT: 7856.21

COMMENTS:   Date of Deposit: MAY 10, 1994

          Enter ?? for more actions
CI  Go to Claim Screen          AL Go to Active List        EX Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
AR Comment History              May 17, 1996 14:21:37          Page:    1 of    1
L10260   JONES,ANDREW     A9281        DOB: 5/22/50    Subsc ID:  AH33334
AR Status:  CANCELLED          Orig Amt: 1026.02       Balance D ue: 1026.02

1582  04/21/92  Copy of bill sent.                  FOLLOW-UP DT:  05/12/92
                Carrier did not receive initial bill.

1594  05/20/92  Bill canceled, wrong form type.    FOLLOW-UP DT:  06/01/92
                Carrier refuses to process this type of bill on a UB-92.
                They are requiring the HCFA 1500 form.

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Co mpany
DX  Bill Diagnosis        AD  Add AR Comment        VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Act ive List    EX  Exit Action
Select Action: Quit//
```

```
Insurance Reviews/Contacts      May 31, 1995 @10:07:11        Page:    1 of    1
Insurance Review Entries for:  N10072     JONES,ANDREW     A9281
    Date       Ins. Co.           Type Contact       Act ion    Auth. No.  Days

    OUTPATIENT VISIT of AMBULATORY SURGERY OFFICE on 11/16/93
1   11/30/93   HEALTH INS LIMITED  1st Appeal-Clin    APPROVED  AU 39824
2   11/17/93   HEALTH INS LIMITED  OPT                DENIAL                0

    PRESCRIPTION REFILL of 30948 on 11/17/93
3   11/17/93   HEALTH INS LIMITED  OPT                APPROVED  RN 9384222

          Service Connected: NO   Previous Spec. Bills: TORT                >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Pol icy
PR  Bill Procedures       VR  Reviews/Appeals       AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Expanded Appeals/Denials      May 31, 1995 @10:07:11            Page 1 of  2
Insurance Appeal/Denial for: JONES,ANDREW     A9281     ROI: NOT REQUIRED

          Visit Information                    Action Information
        Visit Type:  OUTPATIENT VISIT        Type Contact:  INITIAL APPEAL
        Visit Date:  03/09/94 9:00 am         Appeal Type:  CLINICAL
            Clinic:  AMBULATORY SURGERY       Case Status:  OPEN
      Appt. Status:  CHECKED OUT          No Days Pending:
        Appt. Type:  REGULAR                Final Outcome:
      Special Cond:

         Clinical Information              Appeal Address Information
          Provider:                         Ins. Co. Name:  HEALTH INS LIMITED
          Provider:                        Alternate Name:
         Diagnosis:                         Street line 1:  HIL - APPEALS OFFICE
         Diagnosis:                         Street line 2:  1099 THIRD AVE, SUITE
      Special Cond:                         Street line 3:
                                           City/State/Zip:  TROY, NY  12345

                      Insurance Policy Information
    Ins. Co. Name:  HEALTH INS LIMITED    Subscriber Name:  JONES,ANDREW
     Group Number:  GN 48923222             Subscriber ID:  9849333
  Whose Insurance:  VETERAN                Effective Date:  01/01/87
   Pre-Cert Phone:  444-444-444 E          Expiration Date:

    User Information                      Contact Information
      Entered By:  SMITH,ALICE             Contact Date:  04/01/94
      Entered On:  11/16/93 3:30 pm    Person Contacted:  JANE,DOWNY
  Last Edited By:                        Contact Method:  PHONE
  Last Edited On:                       Call Ref. Number:  RN 3320944
                                             Review Date:  06/02/95

 Comments
 Policy should cover treatment.
 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED

          Enter ?? for more actions                                      >>>
CI  Go to Claim Screen       AL Go to Active List    EX Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Expanded Insurance Reviews     May 31, 1995 @10:07:11            Page 1 of   2
Insurance Review Entries for:                                JONES,ANDREW     A9281
                    ROI: NOT REQUIRED

   Contact Information                          Action Information
     Contact Date:  11/17/93                Type Contact:  OUTPATIENT TREATMEN
 Person Contacted:  Steve                  Opt Treatment:  RX REFILL
   Contact Method:  PHONE                         Action:  APPROVED
 Call Ref. Number:  RN 9384222             Auth. Number:  RN 9384222
      Review Date:  06/02/95

                        Insurance Policy Information
   Ins. Co. Name:  HEALTH INS LIMITED  Subscriber Name:  JONES,ANDREW
    Group Number:  GN 48923222           Subscriber ID:  9849333
 Whose Insurance:  VETERAN              Effective Date:  01/01/87
  Pre-Cert Phone:  933-3434            Expiration Date:

   Appeal Address Information           User Information
   Ins. Co. Name:  HEALTH INS LIMITED            Entered By: SMITH,ALICE
  Alternate Name:                                Entered On: 11/17/93 12:54 pm
   Street line 1:  HIL - APPEALS OFFICE       Last Edited By: SMITH,ALICE
   Street line 2:  1099 THIRD AVE, SUITE 301  Last Edited On: 11/20/93 12:55 pm
   Street line 3:
  City/State/Zip:  TROY, NY 12345

 Comments
 One refill of prescription approved.

 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                        >>>
CI  Go to Claim Screen        AL Go to Active List          EX Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.
Insurance Company Screen

Insurance Company May 17, 1996 15:25:42 Page: 1 of 5
Insurance Company Information for: HEALTH INS LIMITED Primary
Type of Company: HEALTH INSURANCE Currently Active

Billing Parameters

Signature Required?:	YES	Attending Phys. ID:	AT PH ID VAH500000
Reimburse?:	WILL REIMBURSE	Hosp. Provider No.:	
Mult. Bedsections:	YES	Primary Form Type:	
Diff. Rev. Codes:		Billing Phone:	
One Opt. Visit:	NO	Verification Phone:	
Amb. Sur. Rev. Code:		Precert Comp. Name:	ABC INSURANCE
Rx Refill Rev. Code:		Precert Phone:	444-444-4444 E
Filing Time Frame:			

Main Mailing Address

Street:	2345 CENTRAL AVENUE	City/State:	ALBANY, NY 12345
Street 2:	FREAR BUILDING	Phone:	456-1234
Street 3:		Fax:	848-4884

Inpatient Claims Office Information

Street:	2345 CENTRAL AVENUE	City/State:	ALBANY, NY 12345
Street 2:	FREAR BUILDING	Phone:	456-0392
Street 3:		Fax:	848-4432

Outpatient Claims Office Information

Street:	789 3RD STREET	City/State:	ALBANY, NY 12345
Street 2:		Phone:	333-444-5676
Street 3:		Fax:	333-444-9245

Third Party Joint Inquiry

EXAMPLE, cont.
Insurance Company Screen, cont.

```
                    Prescription Claims Office Information
   Company Name:  GHI PROCESSING              Street 3:
         Street:  1933 CORPORATE DRIVE      City/State:  RIVERSIDE, NY 39332
      Street 2:  TANGLEWOOD PARK                 Phone:  339-0000
            Fax:

                       Appeals Office Information
         Street:  HIL - APPEALS OFFICE      City/State:  TROY, NY 12345
      Street 2:  1099 THIRD AVE, SUITE 301       Phone:  436-1923
      Street 3:                                    Fax:  436-5464

                       Inquiry Office Information
         Street:  2345 CENTRAL AVENUE       City/State:  ALBANY, NY 12345
      Street 2:  FREAR BUILDING                  Phone:  456-1923
      Street 3:                                    Fax:  848-5336

  Remarks

  Synonyms

          Enter ?? for more actions                                          >>>
BC  Bill Charges           AR  Account Profile        VI  Insurance Company
DX  Bill Diagnosis         CM  Comment History        VP  Policy
PR  Bill Procedures        IR  Insurance Reviews      AB  Annual Benefits
CI  Go to Claim Screen     HS  Health Summary         EL  Patient Eligibility
                           AL  Go to Active List      EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Patient Policy Information     May 31, 1995 @10:07:11       Page:     1 of    3
Extended Policy Information for:   JONES,ANDREW   000-000-9281        Primary
HEALTH INS LIMITED Insurance Company                ** Plan Currently Active **

      Plan Information                          Insurance Company
  Is Group Plan:  YES                          Company:  HEALTH INS LIMITED
     Group Name:                                Street:  2345 CENTRAL AVENUE
   Group Number:  GN 48923222                 Street 2:  FREAR BUILDING
   Type of Plan:                              Street 3:
                                            City/State:  ALBANY, NY 12345

    Utilization Review Info                 Effective Dates & Source
          Require UR:                      Effective Date:  01/01/87
    Require Pre-Cert:                     Expiration Date:
    Exclude Pre-Cond:                      Source of Info:  INTERVIEW
 Benefits Assignable:  YES

     Subscriber Information          Subscriber's Employer Information
   Whose Insurance:  VETERAN   Claims to Employer:  No, Send to Insurance
   Subscriber Name:  JONES,ANDREW         Company:
      Relationship:  PATIENT               Street:
  Insurance Number:  9849333             City/State:
  Coord.  Benefits:  PRIMARY                  Phone:

        User Information                Insurance Contact (last)
       Entered By:  SMITH,ALICE       Person Contacted:
       Entered On:  09/07/93         Method of Contact:
  Last Verified By:  SMITH,ALICE       Contact's Phone:
  Last Verified On:  01/03/95             Contact Date:
   Last Updated By:  BROWN,NANCY
   Last Updated On:  04/06/94

 Comment -- Patient Policy
 None

 Comment -- Group Plan

 Personal Riders
    Rider #1:     EXTEND COVERAGE TO 365 DAYS
    Rider #2:     AMBULANCE COVERAGE

+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Annual Benefits                May 17, 1996 15:39:23          Page:    1 of    3
Annual Benefits for: GHI Ins. Co                                          Primary
             Policy: GN 48923222                Ben Yr:  MAR 01, 1993
```

Policy Information

Max. Out of Pocket: $ 500
Ambulance Coverage (%): 85 %

Inpatient

Annual Deductible:	$ 500	Drug/Alcohol Lifet. Max:	$
Per Admis. Deductible:	$ 100	Drug/Alcohol Annual Max:	$
Inpt. Lifetime Max:	$	Nursing Home (%):	
Inpt. Annual Max:	$	Other Inpt. Charges (%):	
Room & Board (%):			

Outpatient

Annual Deductible:	$ 50	Surgery (%):	
Per Visit Deductible:	$ 50	Emergency (%):	85%
Lifetime Max:	$	Prescription (%):	80%
Annual Max:	$	Adult Day Health Care?:	UNK
Visit (%):		Dental Cov. Type:	PERCENTAGE AMOU
Max Visits Per Year:		Dental Cov. (%):	48%

Mental Health Inpatient

MH Inpt. Max Days/Year:	
MH Lifetime Inpt. Max:	$
MH Annual Inpt. Max:	$
Mental Health Inpt. (%):	

Mental Health Outpatient

MH Opt. Max Days/Year:	
MH Lifetime Opt. Max:	$
MH Annual Opt. Max:	$
Mental Health Opt. (%):	

Home Health Care

Care Level:	
Visits Per Year:	
Max. Days Per Year:	
Med. Equipment (%):	
Visit Definition:	

Hospice

Annual Deductible:	$
Inpatient Annual Max.:	$
Lifetime Max.:	$
Room and Board (%):	
Other Inpt. Charges (%):	

Rehabilitation

OT Visits/Yr:	
PT Visits/Yr:	
ST Visits/Yr:	
Med Cnslg. Visits/Yr:	

IV Management

IV Infusion Opt?:	UNK
IV Infusion Inpt?:	UNK
IV Antibiotics Opt?:	UNK
IV Antibiotics Inpt?:	UNK

User Information

Entered By: BROWN,NANCY
Entered On: 02/02/94
Last Updated By: BROWN,NANCY
Last Updated On: 02/18/94

```
          Enter ?? for more actions                                        >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Patient Eligibility          May 20, 1996 07:45:44          Page:    1 of    1
N10273   JONES,ANDREW  A9281            DOB: 07/07/50   Subsc ID:

            Means Test: CATEGORY A                        Insured: Yes
          Date of Test: 08/24/94                       A/O Exposure:
  Co-pay Exemption Test:                               Rad. Exposure:
          Date of Test:

     Primary Elig. Code: NSC
    Other Elig. Code(s): EMPLOYEE
                         AID & ATTENDANCE
      Service Connected: No
     Rated Disabilities: BONE DISEASE (0%-NSC)
                         DEGENERATIVE ARTHRITIS (40%-NSC)


          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EX  Exit Action
                          AL  Go to Active List
Select Action: Quit//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master


New Option


The IB SUPERVISOR security key is required to edit.

Introduction

This option is used for the maintenance of Third Party rates and charges. It contains the List Manager screens which display all rate elements/fields. It also includes enter and edit actions so each element can be updated. All edit actions within these screens require the IB SUPERVISOR key.

Screen Descriptions

Introduction Screen
This screen displays a brief description of the elements of the Charge Master that may be viewed/edited through this option. You can display/edit rate types, billing rates, charge sets, and rate schedules.

Rate Type Screen
This is a display/edit screen for Billing Rate Types. All Rate Types currently defined are displayed.

Billing Rates Screen
This is a display/edit screen for Billing Rates. All Billing Rates currently defined are displayed. Part of the definition of a Billing Rate includes what types of item the rate's charges are associated with (Billable Item) and how the charge should be calculated (Charge Method).

Charge Set Screen
This is a display/edit screen for Charge Sets. All Charge Sets currently defined will be displayed. These sets define a sub-set of charges for a Billing Rate. The editing of Charge Sets is restricted to non-critical elements if there are Charge Items defined for the set. Since Revenue Code and Bedsection are required to add charges to a bill, the Default Revenue Code and Default Bedsection are required unless these are defined for each individual Charge Item in the Set.

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Introduction, cont.

Charge Item Screen
This is a display/edit screen for Charge Items. These are the actual records of the item and its corresponding charge. This screen displays items that have active charges in a specified date range for the selected Charge Set. All active Charge Items are displayed for a Charge Set with a Billable Item of Bedsection. However, this screen has been specifically limited to displaying either one CPT or one AWP item at a time. The Effective Date is required for all entries and controls when the charge is active. Each item entry overrides any previously effective charge for the item. A Revenue Code is only required if the Revenue Code for the item is different from the Default Revenue Code of the Charge Set.

Billing Regions Screen
This is a display/edit screen for Billing Regions. All Billing Regions currently defined will be displayed. Billing Regions can be set-up which contain the set of divisions that are billed the same charges for a particular Billing Rate. A Billing Region need only be defined if the charges for a rate vary by region/locality/division and more than one Region will be billed at the site. Currently only Billing Rates based on CPT charges may vary by region.

Rate Schedule Screen
This is a display/edit screen for Rate Schedules. These schedules link the charges and the types of bills they may be added to. All Rate Schedules currently defined are displayed. Rate Schedules must be defined for both inpatient and outpatient charges for a Rate Type and all Charge Sets that may be charged to that type of bill should be added. A Charge Set can set-up to be automatically added to bills or to require user input before the charges are added. The effective dates should only be added if there is a specific date that billing to the payer can start or stop.

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example

Introduction Screen

```
Introduction                  May 29, 1997 13:09:26          Page:    1 of    1
Only authorized persons may edit this data: IB SUPERVISOR key required to edit.

Rate Type:                Type of Payer.

Billing Rate:             Type of Charge.

Charge Set:               Charges for a specific Billing Rate, broken down by
                          type of event to be billed/charged.

                          Charge Item:       The individual items for a Set
                                             and their charge amounts.
                          Billing Region:    The region or divisions the
                                             charges apply to.

Rate Schedule:            Definition of charges billable to specific payers.
                          Link between Charge Sets and Rate Types.
                          Once the Rate Type is set for a bill, the
                          Rate Schedule will be used to find all charges to
                          add to the bill.
          Enter ?? for more actions
RS  Rate Schedules         RT  Rate Types
CS  Charge Sets            BR  Billing Rates
Select Action: Quit//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Rate Types Screen

```
Rate Types                    May 29, 1997 13:14:25          Page:    1 of    5
This is a Standard file with entries released nationally.


    Rate Type: CHAMPUS
    Bill Name: CHAMPUS                   AR Category: CHAMPUS
 Abbreviation: CHAMPUS                  Who's Respns: INSURER
 Third Party?: YES                     RI Statement?: YES
     Inactive:                        NSC Statement?: YES

    Rate Type: CHAMPVA REIMB. INS.
    Bill Name: REIMBURSABLE INS.         AR Catego ry: CHAMPVA THIRD PARTY
 Abbreviation: REIM INS                 Who's Respns: INSURER
 Third Party?: YES                     RI Statement?: YES
     Inactive:                        NSC Statement?: YES

    Rate Type: CRIME VICTIM
    Bill Name: THIRD PARTY               AR Category: CRIME OF PER.VIO.
 Abbreviation: CRIME                    Who's Respns: INSURER
 Third Party?: YES                     RI Statement?:
     Inactive:                        NSC Statement?: YES
+         Enter ?? for more actions
ED  Edit Rate Type        MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Billing Rates Screen

```
Billing Rates                 May 29, 1997 13:16:47          Page:    1 of    1

  Rate                              Abbrv       Distrb     Bill Item    Chg Mthd

  INTERAGENCY                       IA          NATIONAL   BEDSECTION   COUNT
  TORTIOUSLY LIABLE                 TORT        NATIONAL   BEDSECTION   COUNT
  VA COST                           VA COST     NATIONAL                VA COST

  AMBULATORY SURGERY                ASC         LOCAL      CPT          COUNT
  AVERAGE WHOLESALE PRICE           AWP         LOCAL      NDC #        QUANTITY
  CMAC                              CMAC        LOCAL      CPT          COUNT




          Enter ?? for more actions
ED  Edit Rate             MS  Main Screen           EX  Exit
Select Action: Quit//
```

Charge Set Screen

```
Charge Sets                   May 29, 1997 13:19:06          Page:    1 of    2
                                                    Default
 Charge Set                   Bill Event  Type  Rv Cd  Bedsection  Region

         Billing Rate: AMBULATORY SURGERY
AMB SURG REGION 1             PROC              500    OUTPATIENT
AMB SURG REGION 2             PROC              490    OPT DNTL

         Billing Rate: INTERAGENCY
IA-INPT                       INPT BEDS         001
IA-OPT DENTAL                 OPT VST DT        512
IA-OPT VST                    OPT VST DT        500
IA-RX FILL                    RX FILL           257

         Billing Rate: TORTIOUSLY LIABLE
TL-INPT (INCLUSIVE)           INPT BEDS         001
TL-INPT (NPF)                 INPT BEDS   INST
TL-INPT (PF)                  INPT BEDS   PROF  960
TL-CAT C OPT COPAY            OPT VST DT        500
TL-OPT DENTAL                 OPT VST DT        512
+         Enter ?? for more actions
CI  Charge Items          RG  Billing Regions       BR  Billing Rates
ED  Edit Charge Set       MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Charge Items Screen

```
Charge Items                  May 29, 1997 13:25:32          Page:    1 of    1
BEDSECTION items billable to Charge Set TL-INPT (INCLUSIVE) on 05/29/97
Default Revenue Code: 001
  Charge Item                        Unit Charge   Rv Cd    Effective  Inactive
  ALCOHOL AND DRUG TREATMENT           300.00               05/27/97
  BLIND REHABILITATION                 973.00               10/01/96
  GENERAL MEDICAL CARE                1046.00               10/01/96
  INTERMEDIATE CARE                    428.00               10/01/96
  NEUROLOGY                           1014.00               10/01/96
  NURSING HOME CARE                    288.00               10/01/96
  PSYCHIATRIC CARE                     501.00               10/01/96
  REHABILITATION MEDICINE              822.00               10/01/96
  SPINAL CORD INJURY CARE              977.00               10/01/96
  SURGICAL CARE                       1923.00               10/01/96

          Enter ?? for more actions
CD  Change Dates          CI  Change Item           BI  Bi lling Item Edit
ED  Edit Charge Item      MS  Main Screen           EX  Exit
Select Action: Quit//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Billing Regions Screen

```
Billing Regions               May 29, 1997 13:34:38          Page:    1 of    1
Sets of divisions covered by the same charges
  Region                  Division

No Billing Regions defined




          Enter ?? for more actions
ED  Edit Region           MS  Main Screen           EX  Exit
Select Action: Quit//
```

Rate Schedules Screen

```
Rate Schedules                May 29, 1997 13:37:01          Page:    1 of    4
Link types of payers and charges
 Schedule              Bill Svs   Charge Set(s)          Effectiv  Inactive Adj

    CRIME VICTIM: Inpatient
CV-INPT                INPT       TL-INPT (NPF)
                                  TL-INPT (PF)

    CRIME VICTIM: Outpatient
CV-OPT                            TL-OPT VST
                                  TL-RX FILL

    DENTAL: Outpatient
DNTL-OPT DENTAL                   TL-OPT DENTAL

    HUMANITARIAN: Inpatient
HMN-INPT               INPT       TL-INPT (INCLUSIVE)

    HUMANITARIAN: Outpatient
HMN-OPT                           TL-OPT VST
                                  TL-RX FILL
+         ~ charges not auto added to bills                              >>>
ED  Edit Schedule         MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

MCCR System Definition Menu
Charge Master Menu
Print Charge Master

New Option

Introduction

This option provides reports for all elements of the Charge Master and maintenance of Third Party rates. The full Charge Item report may be very long if many items have been added, such as CMAC (CHAMPUS Maximum Allowable Charges) charges.

Example

```
Charge Master Reports:


     Select one of the following:

          R         RATE SCHEDULES
          C         CHARGE SETS
          I         CHARGE ITEMS
          B         BILLING RATES
          T         RATE TYPES
          G         BILLING REGIONS
          O         OTHER BILLABLE ITEMS
          X         (OLD RATES FILE)

Select Report: T  RATE TYPES
Report requires 132 columns.
DEVICE: <RET> LAT    RIGHT MARGIN: 80// 132

RATE TYPE LIST                                                                  MAY 27,1997  08:48    PAGE 1
                                                                                                      NSC
                                                                    THIRD                             STATEMENT
NAME                 BILL NAME             INACTIVE  ABBREVIATION  PARTY  ACCOUNTS RECEIVABLE   WHO'S        REIM B  ON UB
                                                                    BILL?  CATEGORY               RESPONSIBLE  INS?    BILLS
-------------------- --------------------- --------  ------------  -----  ---------------------  -----------  ------  ------

CHAMPUS              CHAMPUS                         CHAMPUS       YES    CHAMPUS                INSURER      YES     YES
CHAMPVA REIMB. INS.  REIMBURSABLE INS.               REIM INS      YES    CHAMPVA THIRD PARTY    INSURER      YES     YES
CRIME VICTIM         THIRD PARTY                     CRIME         YES    CRIME OF PER.VIO.      INSURER      NO      YES
DENTAL               DENTAL                          DENTAL        NO     EMERGENCY/HUMANITARI   PATIENT      YES     YES
HUMANITARIAN         HUMANITARIAN                    HUMAN         NO     EMERGENCY/HUMANITARI   PATIENT      NO      NO
INTERAGENCY          INTERAGENCY                     INTER         YES    INTERAGENCY            OTHER (INST          YES
MEANS TEST/CAT. C    MEANS TEST/CAT. C     NO        MT/CAT C      NO     C (MEANS TEST)         PATIENT      NO      YES
MEDICARE ESRD        MEDICARE ESRD                   MEDICARE      YES    INTERAGENCY            OTHER (INST  NO      YES
MILITARY             MILITARY              NO        MIL           YES    INTERAGENCY            OTHER (INST          YES
NO FAULT INS.        NO FAULT INS.                   NO FAULT      YES    REIMBURS.HEALTH INS.   INSURER      NO      YES
REIMBURSABLE INS.    REIMBURSABLE INS.               REIM INS      YES    REIMBURS.HEALTH INS.   INSURER      YES     YES
SHARING AGREEMENT    SHARING AGREEMENT               SHARING       YES    SHARING AGREEMENTS     OTHER (INST          YES
```

MCCR System Definition Menu
Charge Master Menu
Fast Enter of New Billing Rates

New Option

The IB SUPERVISOR security key is required to edit.

Introduction

This option is designed to allow quick entry of new rates into the Charge Master for Interagency and Tortiously Liable Billing Rates. This option should only be used for the annual updated Interagency and Tortiously Liable Rates. The charges will be asked for by charge type category: inpatient, outpatient, prescription, outpatient dental, Cat C copayment. Enter all charges for a category, then move to the next section for the next category. For example, you are first prompted for Inpatient Charges. When you have entered all inpatient bedsections and their related charges, a <RET> entered at the "Select Inpatient Bedsection" prompt will bring you to the next charge type, Outpatient, and so on until you have entered the charges for all charge types.

Revenue codes may be edited through the Enter/Edit Charge Master option.

Example

```
Fast Enter of Tortiously Liable and Interagency Rates


     Select one of the following:

          T         Tortiously Liable
          I         Interagency

Enter which rates: t  Tortiously Liable
Select EFFECTIVE DATE:  10/1  (OCT 01, 1997)

Enter the Revenue Code to use for all non-professional inpatient services:

Room, Board, Nursing Services: 101// <RET>    ALL INCL R&B      ALL-INCLUSIVE
ROOM AND BOARD
Ancillary Services: 240// <RET>     ALL INCL ANCIL      GENERAL CLASSIFICATION
```

MCCR System Definition Menu
Charge Master Menu
Fast Enter of New Billing Rates

Example, cont.

```
TORTIOUSLY LIABLE charges effective Oct 01, 1997 will be added as follows:
Charge Type                    Charge Set              Rev Code
-------------------------------------------------------------------------------
INPATIENT                   TL-INPT (INCLUSIVE)      001       (All Inclusive)
                            TL-INPT (NPF)            101       (Room,board)
                            TL-INPT (NPF)            240       (Ancillary)
                            TL-INPT (PF)             960       (Physician)
OUTPATIENT VISIT            TL-OPT VST               500
PRESCRIPTION REFILL         TL-RX FILL               257
OUTPATIENT DENTAL           TL-OPT DENTAL            512
CAT C OUTPATIENT COPAYMENT  TL-CAT C OPT COPAY       500

If any of the revenue codes are incorrect then change the Default Revenue for
the Charge set. (except the non-prof inpt rev codes entered above)

If any of the Charge Sets are incorrect DO NOT USE this option.
This option may NOT be used to delete rates or add zero charges.

The charges will be asked in sections based on the Charge Types listed above.
The first section is INPATIENT, enter all Inpatient Bedsections and their
charges, then press return at the Select Bedsection prompt to move to the
OUTPATIENT VISIT section and enter the Outpatient Visit Bedsection and charge...

Enter RETURN to continue or '^' to exit: <RET>

-------------------------------------------------------------------------------
Enter INPATIENT TORTIOUSLY LIABLE charges effective Oct 01, 1997:
-------------------------------------------------------------------------------

          Select INPT BEDSECTION: <RET>

-------------------------------------------------------------------------------
Enter OUTPATIENT VISIT TORTIOUSLY LIABLE charges effective Oct 01, 1997:
-------------------------------------------------------------------------------

          Select OPT VISIT BEDSECTION: OUTPATIENT VISIT// <RET>          12
OUTPATIENT VISIT                                 500  $ = <RET>

          Select OPT VISIT BEDSECTION: <RET>

-------------------------------------------------------------------------------
Enter PRESCRIPTION REFILL TORTIOUSLY LIABLE charges effective Oct 01, 1997:
-------------------------------------------------------------------------------

          Select RX REFILL BEDSECTION: PRESCRIPTION// <RET>          9
PRESCRIPTION                                     257  $ = <RET>

          Select RX REFILL BEDSECTION: <RET>
```

MCCR System Definition Menu
Charge Master Menu
Fast Enter of New Billing Rates

Example, cont.

```
--------------------------------------------------------------------------------
Enter OUTPATIENT DENTAL TORTIOUSLY LIABLE charges effective Oct 01, 1997:
--------------------------------------------------------------------------------

          Select OPT DENTAL BEDSECTION: OUTPATIENT DENTAL//  <RET>
OUTPATIENT DENTAL                                 512  $ = 100.00//  <RET>

          Select OPT DENTAL BEDSECTION:  <RET>

--------------------------------------------------------------------------------
Enter CAT C OUTPATIENT COPAYMENT TORTIOUSLY LIABLE charges effective Oct 01,
1997:
--------------------------------------------------------------------------------

          Select CAT C OPT COPAY BEDSECTION: OUTPATIENT VISIT//  <RET>       12
OUTPATIENT VISIT                                  500  $ =  200            added

          Select CAT C OPT COPAY BEDSECTION:  <RET>
```

MCCR System Definition Menu
Charge Master Menu
Delete Charges from the Charge Master

New Option

The IB SUPERVISOR security key is required to edit.

Introduction

This option is used to delete charges from a Charge Set that are no longer needed. All charges that are inactive or that have been replaced before the specified date are deleted. A report of charges that *will be* deleted based on the date entered can be printed before the actual deletion to confirm the charges should be deleted.

Example 1 - Print List of Charges

```
**** DELETE INACTIVE CHARGE ITEMS FROM A CHARGE SET ****

For a given Charge Set, this option allows deletion of all chargeable items
that have been inactivated or replaced before a certain date.

     Since all charges for a billing rate and date range ma y be deleted with
     this option, caution is advised.


The Charge Set to delete Charge items from:
Select CHARGE SET NAME: TL-OPT DENTAL

Delete ALL charges for this Charge Set? YES

     Select one of the following:

          1         Print List of Charges that will be Deleted
          2         Delete Charges

Enter response: 1  Print List of Charges that will be Deleted
OUTPUT DEVICE: HOME// <RET>  LAT    RIGHT MARGIN: 80// <RET>
```

MCCR System Definition Menu
Charge Master Menu
Delete Charges from the Charge Master

Example 1 - Print List of Charges, cont.

```
Charges (to be deleted) in TL-OPT DENTAL set (ALL CHARGES IN SET)May 28, 1997  09:49  Page 1
Charge Item                      Effective   Inactive        Charge   Rev Cd
-------------------------------------------------------------------------------

                    CHARGE SET: TL-OPT DENTAL

OUTPATIENT DENTAL                10/01/92                     97.00
OUTPATIENT DENTAL                10/01/93                    102.00
OUTPATIENT DENTAL                10/01/94                    119.00
OUTPATIENT DENTAL                10/01/95                    104.00
OUTPATIENT DENTAL                10/01/96                    121.00

5 Charges to be deleted
Enter RETURN to continue or '^' to exit:
```

Example 2 - Delete Charges

```
**** DELETE INACTIVE CHARGE ITEMS FROM A CHARGE SET ****

For a given Charge Set, this option allows deletion of all chargeable items that have been
inactivated or replaced before a certain date.

     Since all charges for a billing rate and date range may be deleted with
     this option, caution is advised.


The Charge Set to delete Charge items from:
Select CHARGE SET NAME:  TL-OPT DENTAL

Delete ALL charges for this Charge Set? NO

All charges inactive before this date will be deleted:
Select INACTIVE DATE:  10/1/95  (OCT 01, 1995)

     Select one of the following:

          1         Print List of Charges that will be Deleted
          2         Delete Charges

Enter response: 2  Delete Charges


All charges inactive before 10/01/95 for TL-OPT DENTAL will be deleted.

Is this correct, do you want to continue? YES
Beginning Deletions
3 charges deleted.
```

MCCR System Definition Menu
Charge Master Menu
Inactivate/List Inactive Codes in Charge Master

New Option

Introduction

This option searches the charges in the Charge Master for inactive CPT codes. It then inactivates all charges associated with those inactive CPT codes. To confirm the charges should be inactivated, a report of charges for inactive CPT codes may be printed.

Example

Print List

```
**** INACTIVATE CHARGE ITEMS FOR ALL CURRENTLY INACTIVE CPTS ****

     For all Charge Sets based on CPT procedures, this option will add an
     Inactive Date to each Charge Item that is a currently Inactive CPT code.


The date that should be added as the Inactive Date for the Charges
associated with Inactive CPTs:

Select INACTIVE DATE:  t  (MAY 29, 1997)

     Select one of the following:

          1         Print List of Active Charges for Inactive CPT's
          2         Inactivate Charges for Inactive CPT's

Enter response: 1  Print List of Active Charges for Inactive CPT's
OUTPUT DEVICE: HOME// <RET>  LAT    RIGHT MARGIN: 80// <RET>

Charges for Inactive CPT's                        May 29, 1997  13:47  Page 1
Charge Item        Effective   Inactive    Charge Set            Charge   Rev
Cd
-------------------------------------------------------------------------------
00806              02/01/95               AMB SURG REGION       394.00    333
11701              02/01/95               AMB SURG REGION       343.34
11701 - 54         05/01/96               AMB SURG REGION        34.20
25146 - 66         02/01/95               AMB SURG REGION       942.00
25153              05/01/96               AMB SURG REGION       234.23

5 Charges for Inactive CPT's
```

MCCR System Definition Menu
Charge Master Menu
Inactivate/List Inactive Codes in Charge Master

Example, cont.

Inactivate Charges

```
**** INACTIVATE CHARGE ITEMS FOR ALL CURRENTLY INACTIVE CPTS ****

     For all Charge Sets based on CPT procedures, this option will add an
     Inactive Date to each Charge Item that is a currently Inactive CPT code.


The date that should be added as the Inactive Dat e for the Charges
associated with Inactive CPTs:

Select INACTIVE DATE:  t  (MAY 29, 1997)

     Select one of the following:

          1         Print List of Active Charges for Inactive CPT's
          2         Inactivate Charges for Inactive CPT's

Enter response: 2  Inactivate Charges for Inactive CPT's


All charges for currently Inactive CPT codes will become inactive after
05/29/97

Is this correct, do you want to continue? y  YES
Beginning Inactivations
..5 charges inactivated
```